

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed and filed at any time.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be advised of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 0 27023			
												REG. NO.			
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
			EDWARD E. Anderson						October 8, 1980			3:30 P.M.			
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
Male			White			7 20 02			78			MONTHS DAYS		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.			
New Jersey			U.S.						qWicomico			MD.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Salisbury			Peninsula General Hospital			Manager			Insurance						
13a. STATE Md.			13b. COUNTY Wic.			13c. CITY OR TOWN Salisbury			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 1514 Riverside Drive			
14. FATHER'S NAME FIRST Edward			MIDDLE E.			LAST Anderson			15. MOTHER'S MAIDEN NAME FIRST Katherine			LAST Anderson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No			082-05-5962												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												Left Lower Lobe Pneumonia			
5109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												DUE TO, OR AS A CONSEQUENCE OF (b) Right Chronic emphysema.			
												DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cancer Lung with Right pneumonia & Probable Liver metastases.															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
									YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from Nov. 19, 77, to Oct. 10, 1980, that (I) (we) last saw the deceased alive on Oct 10, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED			
22b. SIGNATURE J. S. Sato, MD			22d. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 229 FLORIDA AVE SALISBURY MD. 21801												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 10/9/80			23c. NAME OF CEMETERY OR CREMATORIAL CITY OR TOWN			23d. LOCATION CITY OR TOWN			COUNTY STATE			
24 FUNERAL DIRECTOR NAME Anatomy Board			ADDRESS Balto., Md.			25a. DATE REC'D. BY REGISTRAR OCT 20 1980			25b. REGISTRAR'S SIGNATURE Larry Kelley						

19. *Leucosia* *leucostoma* (Fabricius) *leucostoma* (Fabricius) *leucostoma* (Fabricius)

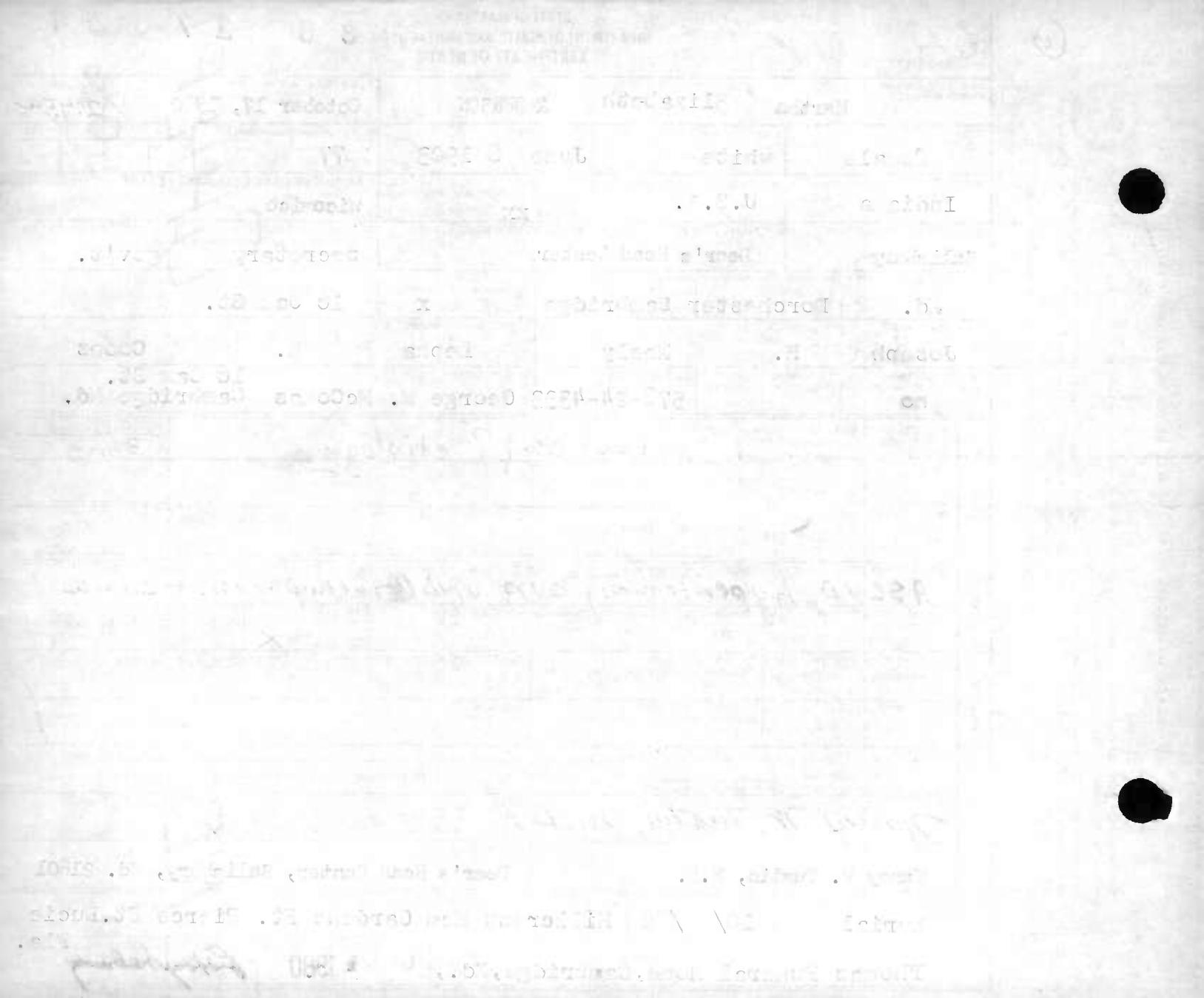
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page _____
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Item 1 and 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 27024													
												REG. NO.													
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH									MONTH	DAY	YEAR	2b. HOUR										
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			October 17, 1980			2:45a.m.										
Martha			Elizabeth			Anderson																			
3. SEX			4. RACE			5. DATE OF BIRTH			16. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS											
female			white			MONTH JUNE DAY 8 YEAR 1903			77			MONTHS		DAYS HOURS MIN											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.										
Indiana			U.S.A.									Wicomico													
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Salisbury			Deer's Head Center									Secretary			gov't.										
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13a. STATE				13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
												Md.				Dorchester		Cambridge			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		16 Oak St.		
14. FATHER'S NAME			FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME													
Joseph			H.						Neely			Lepha			E.										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
no			578-24-4333						seizures, ? etiology			16 Oak St.			3 hrs										
4292												DUE TO, OR AS A CONSEQUENCE OF (b)													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b).												DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												ASCVD, hypertension, CVA with (R) hemiparesis + coma													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED			(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																
			HOUR A.M. MONTH DAY YEAR P.M. 19																						
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION			STREET			CITY OR TOWN		COUNTY		STATE									
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>																									
22a. I certify that (I) (this hospital) attended the deceased from 19 _____, to 19 _____, that (I) (we) last saw the deceased alive on 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																									
22b. SIGNATURE Nancy W. Tustin, M.D.												DEGREE				22c. DATE SIGNED									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nancy W. Tustin, M.D.												ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Mem Gardens Ft. Pierce St. Lucie			23d. LOCATION			STATE													
burial			10/ 80									COUNTY													
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			Fla.													
Thomas Funeral Home, Cambridge, Md.,						Oct 12 1980																			



TO HOSPITAL ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Name 2 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3027025
												REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
BERTHA			E.		BAILEY	10	11	80	7 15	A.M.		
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
FEMALE			NEGRO	MONTH	2	YEAR	82		YRS	MONTHS	MONTHS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
MD.			U.S.A.						WICOMICO			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
SALISBURY			SALISBURY NURSING HOME			FACTORY WORKER						
13a. STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			
MARYLAND			WICOMICO		SALISBURY	YES <input type="checkbox"/> NO <input type="checkbox"/>			ROUTE 50 & CIVIC AVENUE			
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME						
Thomas					Lankford	Mary			Moore			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
No			212-16-7870			Ella King			Quantico, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b) and (c): PART 1. DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a)			4340			a cerebral thrombosis			10 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any			DUE TO, OR AS A CONSEQUENCE OF (b)			generalized arteriosclerosis			45			
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:												
Diabetes mellitus												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			
22a. I certify that (I) (this hospital) attended the deceased from now, the deceased died on 10/10/1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.						Sept. 25, 1980, to 10/10/1980			CITY OR TOWN			
22b. SIGNATURES (NAME OF PHYSICIAN) (TYPE OR PRINT)						CITY OR TOWN			COUNTY			
22c. DEGREE						CITY OR TOWN			STATE			
22d. ADDRESS												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			
BURIAL			10/18/80			Green Acres Mem.			Salisbury Wicomico Md			
24. FUNERAL DIRECTOR JOLLEY FUNERAL HOME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
			Jersey Road			OCT 20 1980			F. Jolley			
DHMH-16 20M (VRA 15, 4) 7/78												

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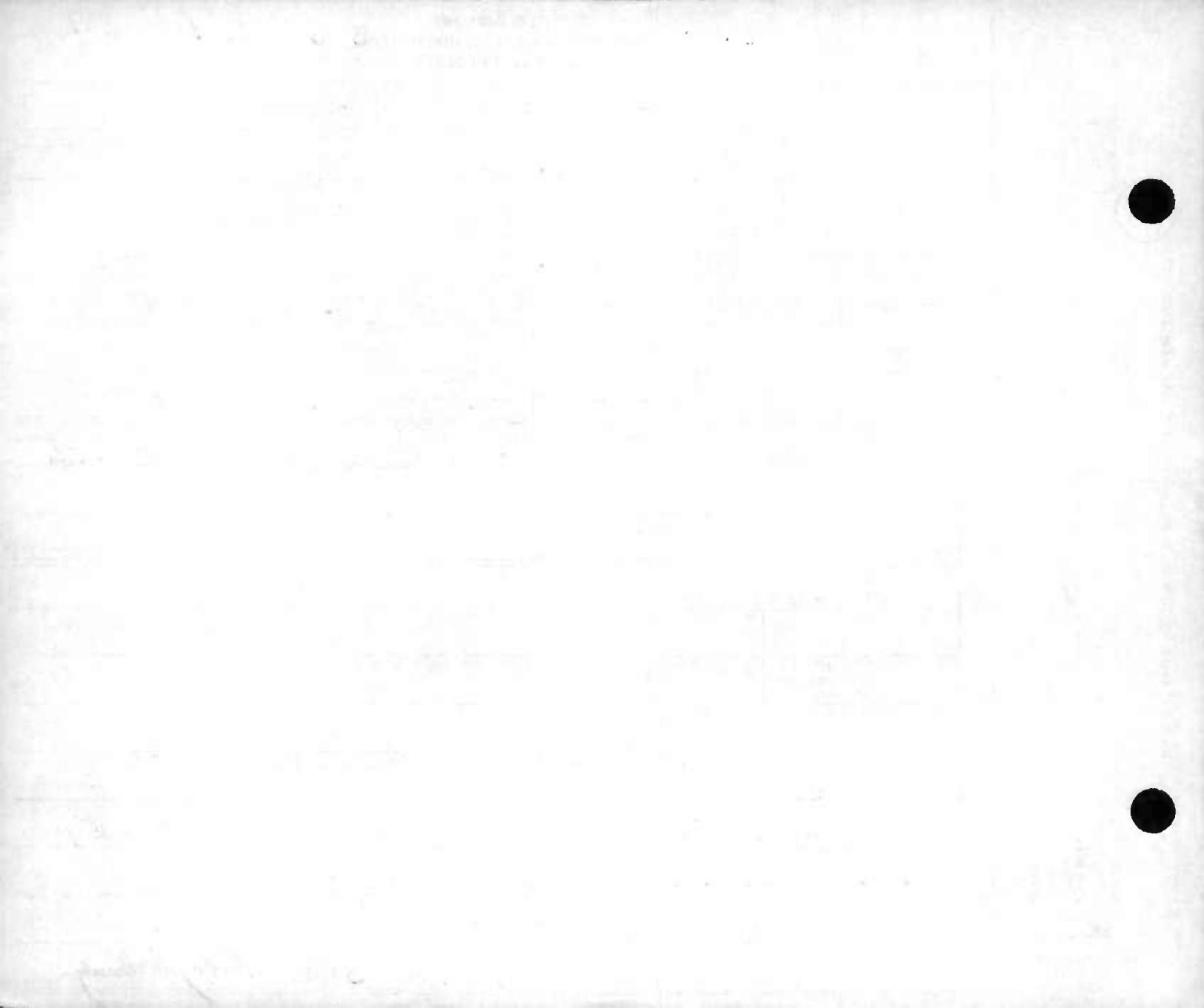
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8027026					
1. STATE REGISTRAR			2. DATE OF DEATH MONTH DAY YEAR									REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2b. HOUR								
E Louise			Bedsworth			October 26, 1980			9:35 P M								
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
Female		white		April 14, 1900			80			MONTHS	YEARS	HOURS	MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.							
Maryland		U.S.					WICOMICO										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
SALISBURY		PENINSULA GENERAL HOSPITAL															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS							
Maryland		Somerset		Princess Anne			NO			Pine Knoll Drive							
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST															
George W. McDaniel		Alice C. Parks															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS										
no		214-30-9235		Russell Bedsworth, Seaford, Dela.													
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH certainty					
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). (b)																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE			
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 10-20 1980, to 10-20 1980, that (I) (we) last above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 10-20-80					
22b. SIGNATURE Wilbur R. Ellis, Jr. MD		22d. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>			STAFF PHYSICIAN <input type="checkbox"/>						
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS			22g. ADDRESS												
Wilbur R. Ellis, Jr. MD		Kay Ave. Salisbury, Maryland 21801															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE				
Burial		10/29/80		Oriole			Oriole, Somerset, Md.										
24. FUNERAL DIRECTOR NAME James L. Sherman, Principal		ADDRESS			25a. DATE REC'D. BY REGISTRAR Oct 20 1980			25b. REGISTRAR'S SIGNATURE Victor Kelley									

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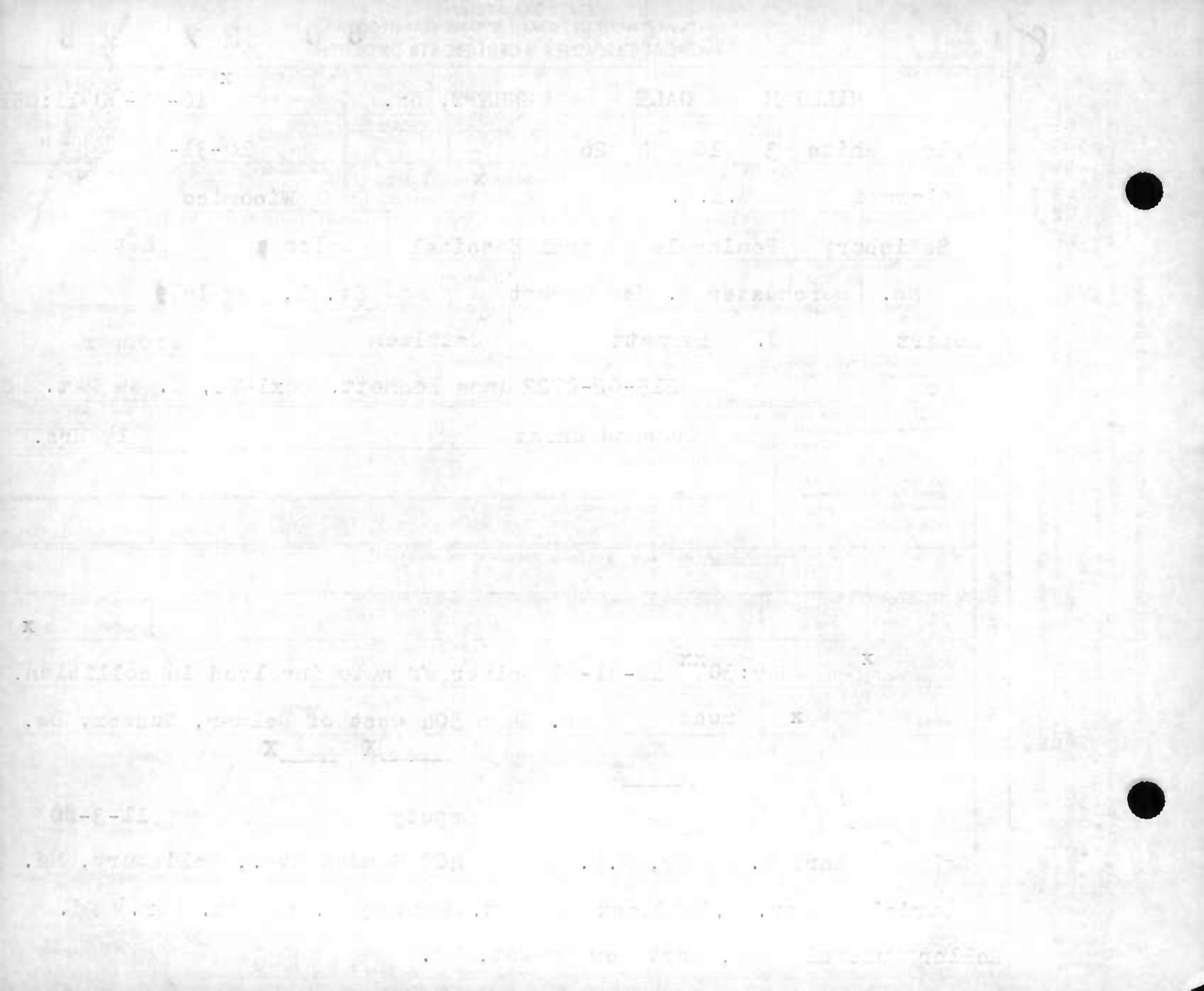
IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												30 27027
												REG. NO.
1. DECEASED NAME (TYPE OR PRINT)	FIRST John	MIDDLE ----	LAST Beirle	2a DATE OF DEATH	MONTH October	DAY 14	YEAR 1980	2b HOUR M				
3 SEX Male	4 RACE White	5. DATE OF BIRTH MONTH Aug.	DAY 20	YEAR 1902	6 AGE (IN YEARS LAST BIRTHDAY) 78	IF UNDER 1 YEAR MONTHS YRS	IF UNDER 24 HRS DAYS HOURS MIN					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED WIDOWED	NEVER MARRIED DIVORCED	9 BALTIMORE CITY OR COUNTY OF DEATH WICOMICO								
10. CITY OR TOWN OF DEATH Parsonsburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holt Road, Rt. 2	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer	12b KIND OF BUSINESS OR INDUSTRY Farming									
13a STATE Maryland	13b COUNTY Wicomico	13c CITY OR TOWN Parsonsburg	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS Rt. 2, Holt Road								
14. FATHER'S NAME FIRST Fritz	MIDDLE	LAST Beirle	15 MOTHER'S MAIDEN NAME FIRST (unknown)									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b SOCIAL SECURITY NO. 219-42-8890	17 INFORMANT Mrs. Frances H. Beirle (wife)	ADDRESS same as 13									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause (c) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ANTHRO salicosis												
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from 10-1, 19 80, to OCTOBER 13, 19 80, that (I) (we) last saw the deceased alive on 10-7 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.	22b. SIGNATURE C. R. Layton, M.D.	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 10/15/80								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. R. Layton, M.D.	22e. ADDRESS Salisbury, Maryland											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 10/15/80	23c. NAME OF CEMETERY OR CREMATORIAL Delmarva Crematory	23d. LOCATION CITY OR TOWN Lewes, Sussex, Delaware	23e. COUNTY STATE								
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md.	ADDRESS HOLLOWAY FUNERAL HOME, Salisbury, Md.	25a. DATE REC'D. BY REGISTRAR OCT 16 1980	25b. REGISTRAR'S SIGNATURE Ricky Belknap									



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201. TO FUNERAL DIRECTOR: PAGE 4 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FORWARDED TO THE BURIAL CEMETERY. PAGE 3 SHOULD BE FORWARDED TO THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 27028							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF DEATH ESTIMATED			2b. HOUR				
WILLIAM GALE BENNETT, SR.												<input checked="" type="checkbox"/> 10-31-80			11:05P				
3. SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c. DATE Pronounced DEAD			2d. HOUR		
Male		White		3 10 54			26 yrs.							10-31-80 19			11 M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH												
Delaware		U.S.A.		<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			Wicomico												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION FOR MOST OF WORKING LIFE			12b. KIND OF BUSINESS OR INDUSTRY											
Salisbury		Peninsula General Hospital			Salesman			Retail											
13. STATE		14. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS										
Md.		Dorchester		E. New Market			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. 1, Box 147C										
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST			LAST												
Robert		G.		Cathleen			Propper												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS												
No		215-02-0722		Anna Bennett, Box 147C, E. New Mkt. Md.															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed Chest												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs.							
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ (c) _____																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?														
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR AM/PM MONTH DAY YEAR 9:30 A.M. 10-31-80			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver of auto involved in collision.														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road			21f. LOCATION STREET Rt. 54 & 504 CITY OR TOWN west of Delmar , COUNTY Sussex , STATE De.														
22a. I certify that I took charge of the remains described above, held on Nov. 3, 1980 Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
23a. ACTUAL EXAMINER'S SIGNATURE <i>Deputy</i> EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.												TITLE (SPECIFY) Deputy MEDICAL EXAMINER							
23b. DATE (SPECIFY) Burial Nov. 3, 1980												DATE SIGNED 11-3-80							
23c. NAME OF CEMETERY OR CREMATORIUM East New Mkt. Cemetery												23d. LOCATION CITY OR TOWN E. New Mkt. Dor. , COUNTY De. , STATE Md.							
24. FUNERAL DIRECTOR NAME Zeller Funeral Home												25a. DATE REC'D. BY REGISTRAR NOV 10 1980							
ADDRESS East New Market, Md.												25b. REGISTRAR'S SIGNATURE <i>Patsy Bradley</i>							

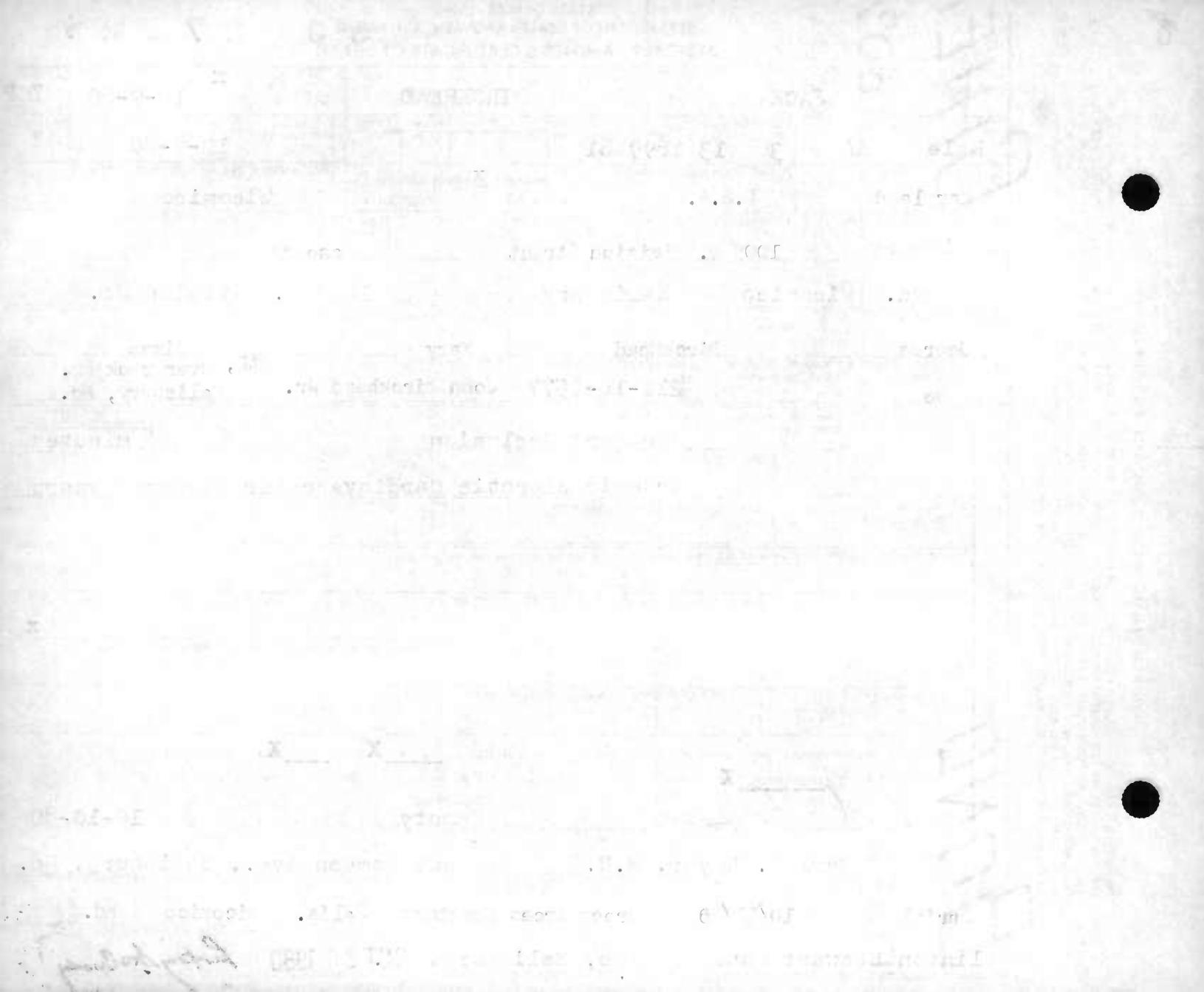


STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 27029

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR	
		JACK		BIRCKHEAD		10-9-80			7 P M	
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS	8. IF UNDER 24 HRS. DAYS				
Male		AA	3 13 1899	81 yrs.						
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		10. CITIZEN OF WHAT COUNTRY?		11. MARRIED WIDOWED		12. NEVER MARRIED DIVORCED		13. DATE PRONOUNCED DEAD		
Maryland		U.S.A.						10-9-80 19		
14. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury		1009 N. Division Street				Masonry				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS				
Md.		Wicomico	Salisbury			1009 N. Division St.				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME					
		George		Birckhead	Mary				Dixon	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No		212-16-7577		John Birckhead Jr.		102, Overbrook Dr.		minutes		
Salisbury, Md.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										
Arteriosclerotic Cardiovascular Disease years										
(b) <u>Arteriosclerotic Cardiovascular Disease years</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE
22a. I certify that I took charge of the remains described above, held an		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input checked="" type="checkbox"/>		and in my opinion		
death resulted from: <u>natural causes</u> <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>		
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER								
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 409 Camden Ave., Salisbury, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 10/13/80	23c. NAME OF CEMETERY OR CREMATORIAL Green Arches Cemetery		23d. LOCATION CITY OR TOWN Salis.		COUNTY Wicomico		STATE Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS Clinton Stewart Funeral Home, Salisbury, Md.		25a. DATE REC'D. BY REGISTRAR OCT 20 1980		25b. REGISTRAR'S SIGNATURE <i>Clinton Stewart</i>				
BP										
DHMH-17 (VR A15 ME(5)) 15M 7/76										



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF CAPITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

27030

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH DAY YEAR			2b. HOU				
Emma I Black						<input checked="" type="checkbox"/>		10-27, 80			12p				
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD			10-27 19 80 12p		
Female	Black	12 22 21			58 yrs.					10-27			19 80 12p		
10. BIRTHPLACE (STATE OR Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico			11. BIRTHPLACE (STATE OR Maryland					
11. CITY OR TOWN OF DEATH Salisbury		12. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital			13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland			13c. CITY OR TOWN Chestertown			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 2 Box 727		
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Miller		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah A. Johnson			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				17. INFORMANT ADDRESS RFD # 2		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1579 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) Esophogeal erosion DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma Pancreas				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1579 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) Esophogeal erosion DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma Pancreas				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1579 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) Esophogeal erosion DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma Pancreas				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1579 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) Esophogeal erosion DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma Pancreas				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes			
19. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> and in my opinion															
ACTUAL SIGNATURE <i>John T. Bulkeley</i> M.D. TITLE (SPECIFY) EXAMINER'S NAME (TYPE OR PRINT) John T. Bulkeley ADDRESS Salisbury, Maryland 21801 EXAMINER'S NAME (TYPE OR PRINT) John T. Bulkeley ADDRESS Salisbury, Maryland 21801 DATE SIGNED 10-29-80															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/1/80		23c. NAME OF CEMETERY OR CREMATORIY Mt. Pleasant Cem. RFD Chestertown, Md.		23d. LOCATION CITY OR TOWN		COUNTY		STATE					
24. FUNERAL DIRECTOR NAME James A. Perkins - Rock Hall, Md.		25a. DATE REC'D. BY REGISTRAR NOV 6 1980		25b. REGISTRAR'S SIGNATURE <i>James A. Perkins</i>											

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DHMH. 17
(VR A15 ME (5))
30M 7/73

73

reduces

the amount of energy available for

the production of energy-rich molecules.

It is the energy available for the production of energy-rich molecules that

is reduced by the presence of a catalyst.

It is the energy available for the production of energy-rich molecules that

is reduced by the presence of a catalyst.

It is the energy available for the production of energy-rich molecules that

is reduced by the presence of a catalyst.

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is reduced by the presence of a catalyst.

It is the energy available for the production of energy-rich molecules that

is reduced by the presence of a catalyst.

27031

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH EST. <input checked="" type="checkbox"/> MATED <input type="checkbox"/> 10 18 80	MONTH DAY YEAR	2b. HOUR PM
Monique Blue					2c. DATE PRONOUNCED DEAD	MONTH DAY YEAR	2d. HOUR PM
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico County	
female	black	12 19 77	2 yrs.			MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED		10. CITY OR TOWN OF DEATH Salisbury	
NY		USA				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital	
12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE NC		13b. COUNTY MOORE		13c. CITY OR TOWN Ragle Springs	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RT 1 Box 22 A		14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. ADDRESS Talbert County Smith BROMAN	
16c. IMMEDIATE CAUSE (a) 9679 IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		16d. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		16e. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR AM MONTH DAY YEAR Unknown 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Battered child		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Unknown		21f. LOCATION STREET Unknown		CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER	
ACTUAL SIGNATURE <i>Hormez R. Guard</i>						DATE SIGNED 10/20/80	
EXAMINER'S NAME (TYPE OR PRINT)		Hormez R. Guard, M.D.		ADDRESS 111 Penn Street, Baltimore, MD 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 10-25-80		23c. NAME OF CEMETERY OR CREMATORY Pressby Twp Cem		23d. LOCATION CITY OR TOWN Jackson J Moore NC	
24. FUNERAL DIRECTOR NAME		ADDRESS George H. Dashill		25a. DATE REC'D. BY REGISTRAR NOV 6 1980		25b. REGISTRAR'S SIGNATURE <i>Patricia Bradley</i>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DAY IS NECESSARY, WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR; PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 3 FOR YOUR USE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME(5))
15M 7/76

100-10

100-1000

A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										0 27032	
REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Marie Ae Bozman						10 6 80			5:00 PM		
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH MONDAY DEC. 25, 1886			6. AGE (IN YEARS LAST BIRTHDAY) 93		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH GOVERNMENT CO. WICOMICO		
10. CITY OR TOWN OF DEATH SALISBURY			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RIVER WALK MANOR			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD.			13b. COUNTY SOMERSET			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		
14. FATHER'S NAME JOHN DAVIS			15. MOTHER'S MAIDEN NAME TOBITHA BOZMAN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO.			16b. SOCIAL SECURITY NO.			17. INFORMANT MRS THORNTON HITCH			ADDRESS ALLEN, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.			RECURRENT VASCULAR ACCIDENT						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day		
(b) DUE TO, OR AS A CONSEQUENCE OF generalized arteriosclerosis											
(c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 2-26, 1980, to 10-6, 1980, that (I) (we) last saw the deceased alive on 10-6, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John G. Bulkeley			22c. DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 10/8/80		
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 10/9/80			23c. NAME OF CEMETERY OR CREMATORIAL ORIOLE CEMETERY			23d. LOCATION CITY OR TOWN COUNTY STATE ORIOLE, MD.		
24. FUNERAL DIRECTOR LEVIN R. WILSON			ADDRESS PRINCESS ANNE, MD.			25a. DATE REC'D. BY REGISTRAR OCT 14 1980			25b. REGISTRAR'S SIGNATURE John G. Bulkeley		

M

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8027033

1 - STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
Victor C.					Bozman	October 18, 1980				4:25 A.M.	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS	
Male		White		Month Day Year Sept. 23, 1906		74		MONTHS	YEARS	HOURS	MIN.
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Maryland		USA				WICOMICO					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY					
SALISBURY		PENINSULA GENERAL HOSPITAL		Employee		Shirt Mfg. Co.					
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13b STREET ADDRESS					
13a STATE Maryland		13b COUNTY Wicomico		13c CITY OR TOWN Salisbury		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		817 Smith Street			
14 FATHER'S NAME FIRST Elmer		MIDDLE Bozman		15 MOTHER'S MAIDEN NAME FIRST Georgie		MIDDLE Bozman		LAST			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS		same as 13			
NO		214-10-7231		Mrs. Catherine P. Bozman (wife)							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiogenic Shock</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Arteriovenous Malformation</i> (c) <i>Congestive heart failure</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10/17/80 to 10/18/80, that (II) (we) last saw the deceased alive on 10/18/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We did not view the body after death.)											
22b. SIGNATURE <i>Raffetto</i>		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 10/18/80					
22e. ADDRESS PGH.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 10/20/80		23c. NAME OF CEMETERY OR CREMATORIAL Parsons Cemetery		23d. LOCATION CITY OR TOWN Salisbury, Wic., Maryland		COUNTY STATE			
Burial											
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md.		ADDRESS		25a. DATE REC'D. BY REGISTRAR OCT 21 1980		25b. REGISTRAR'S SIGNATURE <i>Patricia K. Brady</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

W

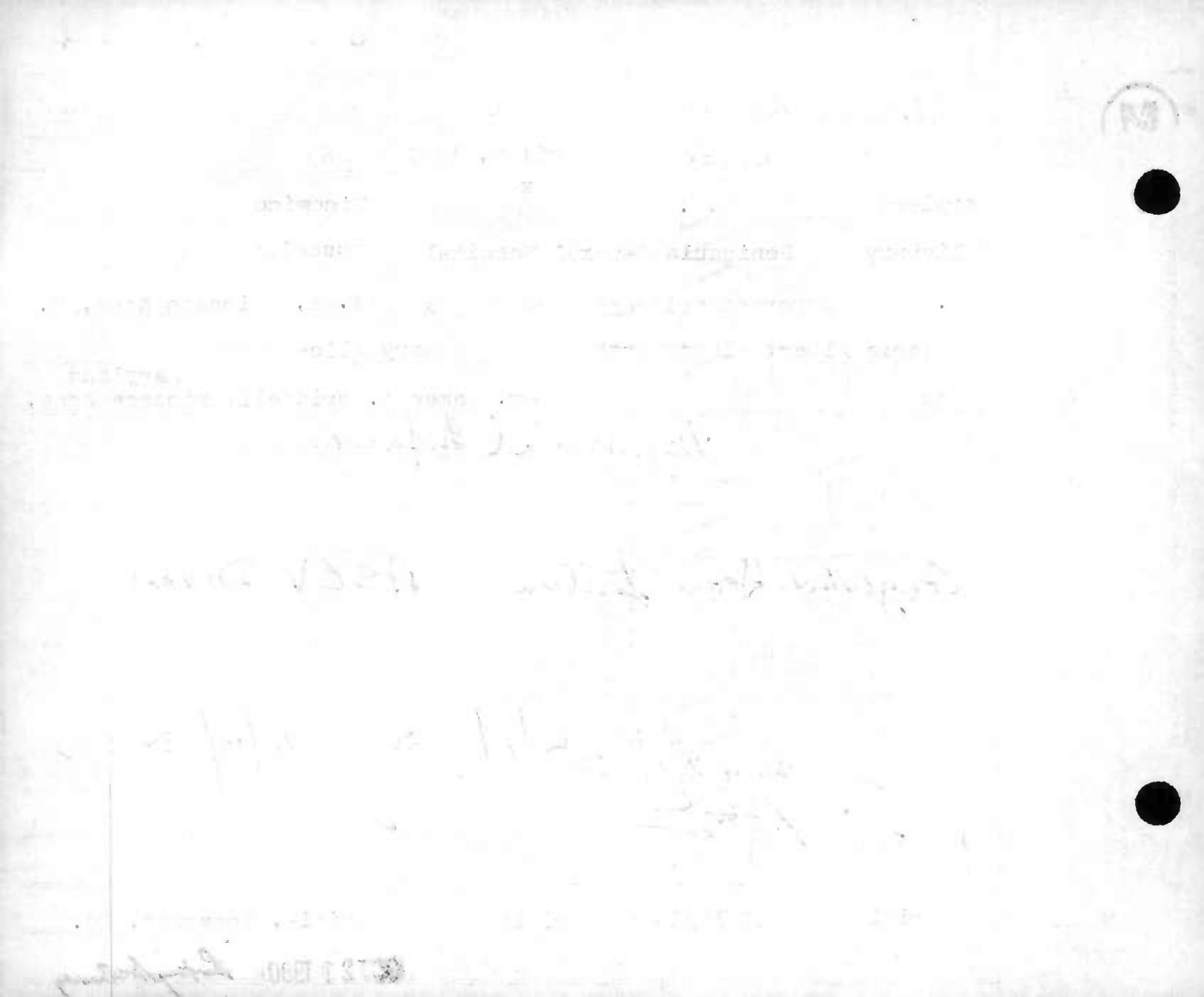
0901 18100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3027034			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)	FIRST			MIDDLE			LAST			20. DATE OF DEATH	MONTH	DAY	YEAR	26. HOUR	
Annie Louise Bridgell										October 15, 1980				11:50 P.M.	
3. SEX	4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS.		
Female	White			MONTH DAY YEAR April 9, 1897			83			MONTHS	YEARS	MONTHS	YEARS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
Maryland	U.S.			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Wicomico								
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)											12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury	Peninsula General Hospital											Housewife	MD.		
13a. STATE Md.	13b. COUNTY Somerset	13c. CITY OR TOWN Princess Anne	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Rt. #1, Princess Anne, Md.									
14. FATHER'S NAME FIRST	MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST		
George	Albert			Bloodsworth			Mary			Alice			Jones		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.			17. INFORMANT			18. ADDRESS			Maryland					
no							Mr. James A. Bridgell: Princess Anne,								
18. CAUSE OF DEATH (Enter only one cause per line for Part 1, Part 2, and Part 3) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)												APPROPRIATE NUMBER BETWEEN DEATH AND DEATH			
410- Condition, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.															
DUE TO, OR AS A CONSEQUENCE OF (b)															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
Congestive Heart Failure												ASCV Disease			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED											20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
19b. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21b. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21c. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21d. LOCATION STREET			CITY OR TOWN			COUNTY	STATE				
22a. I certify that (1) this hospital attended the deceased from saw the deceased alive on <u>Aug 8, 1980</u> to <u>Oct 11, 1980</u> , to <u>Oct 15, 1980</u> , that (2) I last saw the deceased alive on <u>Aug 8, 1980</u> and that in my (1) opinion death occurred on the date and hour and from the causes stated above, (3) (I did) (did not) see the body after death.	22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			COUNTY	STATE				
Burial	10/18/1980			Oriole			Oriole, Somerset, Md.								
24. FUNERAL DIRECTOR NAME	ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Jones L. Hennigan	Princess Anne, Md.			Oct 21, 1980			Lily Hennigan								



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS EXECUTED THE CERTIFICATE, WRITING THE WORD 'PENDING' IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH27035
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR MONTH	DAY	YEAR	2b. HOUR MD.
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS	8. IF UNDER 24 HRS. DAYS HOURS MIN	9. DATE PRONOUNCED DEAD	10. DATE 10-29-80	11. DATE 10-29-80	12. DATE 10-29-80	13. DATE 10-29-80	14. DATE 10-29-80	15. DATE 10-29-80	
Male	White	11 13 22	57 yrs										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH				
Reids Grove, Md.			U.S.A.			X			Wicomico				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Salisbury			Camden Ave. & Market St.			House painter			Hayman's Rooming House, Camden & Market Sts.				
13a. STATE Md.			13b. COUNTY Wicomico	13c. CITY OR TOWN Salisbury	13d. INSIDE CITY LIMITS? YES X	13e. STREET ADDRESS House	14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
					NO		Arthur C. Brinsfield, Sr.			May Elizabeth Insley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			ADDRESS			
No						Jay Brinsfield, 527 Calvert Rd., Rising Sun	Malnutrition			Md. 21911			
							DUE TO, OR AS A CONSEQUENCE OF Cirrhosis of Liver			years			
							DUE TO, OR AS A CONSEQUENCE OF Chronic Alcoholism			years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?							
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/>			and in my opinion							
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
EXAMINER'S NAME (TYPE OR PRINT)			23. DATE SPECIFY			TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER			DATE SIGNED 10-30-80				
Earl L. Royer, M.D.			Oct. 31, 1980			409 Camden Ave., Salisbury, Md.							
23a. BURIAL, CREMATION, REMOVAL SPECIFY			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL CITY OR TOWN			23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			Oct. 31, 1980			Brookview Cemetery			Brookview, Dorchester, Maryland				
24. FUNERAL DIRECTOR NAME			ADDRESS			NOV 5 1980			150 DEADERICK ST. BY REG. MAIL FOR BURIAL				
Frampton & Hawkins, Federalsburg, Md.													



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8027036

REG. NO.

1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
<i>HeLEN Cecelia Brown</i>			October 26, 1980			4:30 P M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS	
Female	White	July 5, 1905	75			IF UNDER 24 HRS MONTHS HOURS MIN	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9. CITIZEN OF WHAT COUNTRY?		10. BALTIMORE CITY OR COUNTY OF DEATH			
<i>Delaware</i>		U.S.A.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
13. CITY OR TOWN OF DEATH SALISBURY		14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		15. MOTHER'S MAIDEN NAME			16. IND OF BUSINESS OR INDUSTRY
SALISBURY		PENINSULA GENERAL HOSPITAL		<i>S. Beauford Brown</i>			TEACHER FOR PUBLIC SCHOOL
17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		18. CITY OR TOWN		19. INSIDE CITY LIMITS?		20. STREET ADDRESS	
13a. STATE <i>MD</i>		13b. COUNTY <i>Wicomico</i>		13c. CITY OR TOWN <i>Salisbury</i>		<i>Parkside-Apts</i>	
21. FATHER'S NAME FIRST MIDDLE LAST		22. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		23. INFORMANT ADDRESS		24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<i>De James S. Cobb</i>		<i>S. Beauford E. Brown</i>		<i>James J. Brown</i>		115 Justice Ave Salisbury, Md.	
25. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)							
PART 1. DEATH WAS CAUSED BY							
IMMEDIATE CAUSE (a) <i>Lung Cancer</i>							
DUE TO, OR AS A CONSEQUENCE OF							
(b) <i>1629</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
26a. MEDICAL CERTIFICATION		26b. DATE OF OPERATION		26c. CONDITION FOR WHICH OPERATION WAS PERFORMED		26d. AUTOPSY?	26e. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
27a. DATE OF OPERATION		27b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
28a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		28b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		28c. LOCATION STREET		28d. CITY OR TOWN	
29a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		29b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		29c. LOCATION STREET		29d. COUNTY	
30a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		30b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		30c. LOCATION STREET		30d. STATE	
31a. I certify that (I) <input type="checkbox"/> (we) <input type="checkbox"/> attended the deceased from <i>10/19</i> , 19 <i>70</i> , to <i>10/26</i> , 19 <i>70</i> , that (I) <input type="checkbox"/> (we) <input type="checkbox"/> lost saw the deceased alive on <i>10/26</i> , 19 <i>70</i> , and that in (my) <input type="checkbox"/> (our) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.							
32a. SIGNATURE <i>Thomas MD</i>							
32b. DEGREE							
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
32c. DATE SIGNED							
33a. PHYSICIAN'S NAME (TYPE OR PRINT)		33b. ADDRESS					
<i>Joseph N. Cross</i>							
34a. DURATION, CREMATION, REMOVAL (SPECIFY)		34b. DATE		34c. NAME OF CEMETERY OR CREMATORIUM		34d. LOCATION CITY, STATE, COUNTY	
<i>BURIAL</i>		<i>10/29/1980</i>		<i>New Cathedral Pk.</i>		<i>Bethel, Md.</i>	
35a. FUNERAL DIRECTOR NAME		35b. ADDRESS		35c. DATE REC'D. BY REGISTRAR		35d. REGISTRAR'S SIGNATURE	
<i>Hill-Baker-Bounds</i>		<i>Salisbury, Md.</i>		<i>OCT 31 1980</i>		<i>Henry Kellogg</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, an other traumatic event, the medical examiner must be notified.

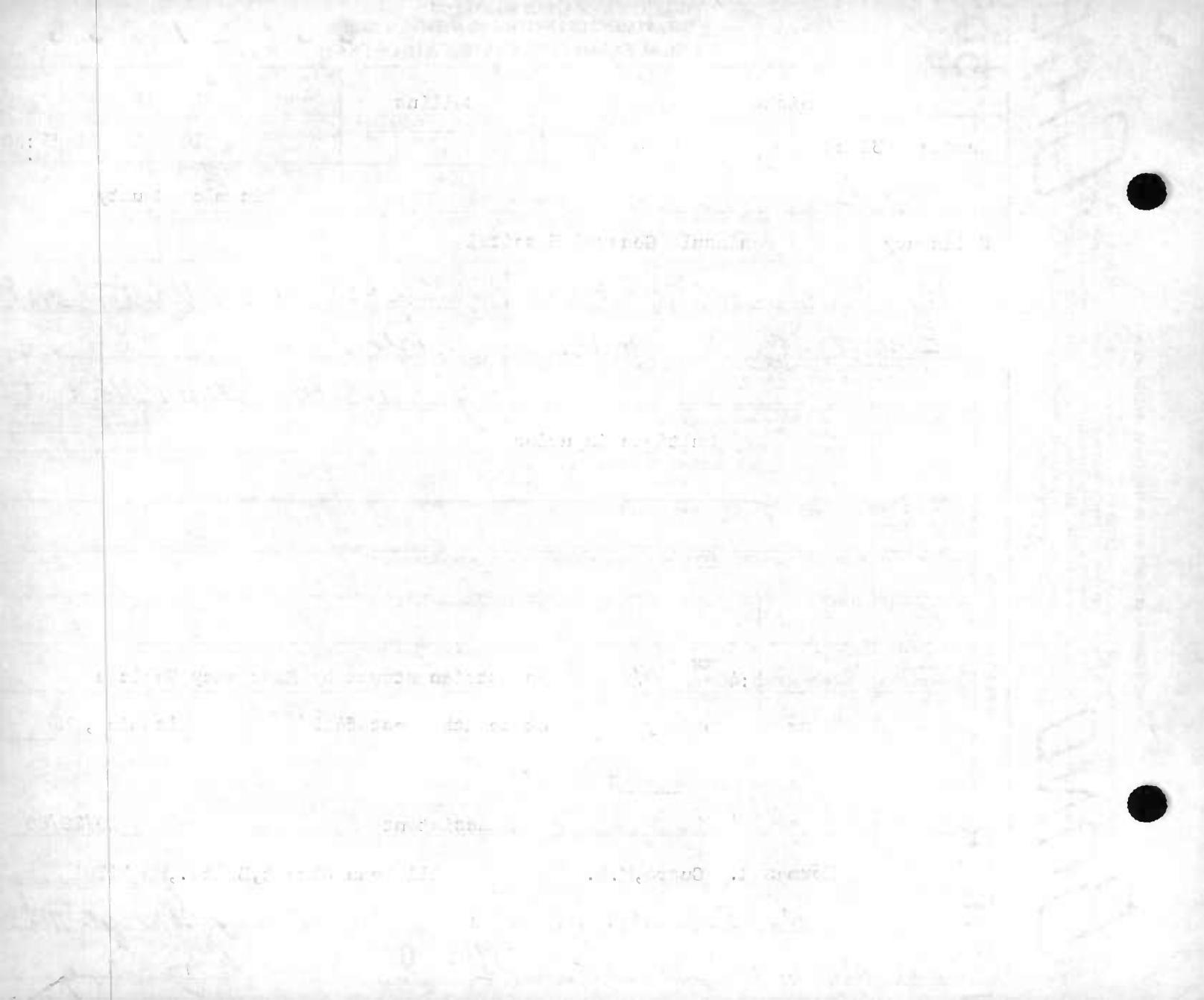
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 0 27037				
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR				
I. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			Oct 24, 1980		8 A. M.		
EBEN H. COLLINS JR.																
3. SEX <i>Male</i>			4. RACE WHITE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
						JULY 8, 1930			50			YEARS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>DELAWARE</i>			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH <i>Wicomico</i>			MD.				
10. CITY OR TOWN OF DEATH <i>Salisbury</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Peninsula General Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>AUTO DEALER</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>SALES</i>							
13a. STATE <i>DELAWARE</i>			13b. COUNTY <i>SUSSEX</i>			13c. CITY OR TOWN <i>MILLSBORO</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS P. O. BOX 578				
14. FATHER'S NAME FIRST EBEN MIDDLE H. LAST COLLINS			15. MOTHER'S MAIDEN NAME FIRST PAULINE MIDDLE COLLINS LAST SIRMAN													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>YES</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>KOREA 222-18-1945</i>			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>lungs Cancer</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
16c. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>1629</i>			16d. DUE TO, OR AS A CONSEQUENCE OF (b)			16e. DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>1017</i>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) this hospital attended the deceased from <i>10/23</i> 19 <i>80</i> to <i>10/24</i> 19 <i>80</i> , that (I) <input checked="" type="checkbox"/> lost the deceased alive on <i>10/23</i> 19 <i>80</i> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.																
22b. SIGNATURE <i>Joseph A. Grasso</i>			22c. DEGREE <i>MD</i>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS <i>1360 S. Division St</i>			22f. DATE SIGNED				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>			23b. DATE <i>10-27-80</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>MILLSBORO CEM.</i>			23d. LOCATION CITY OR TOWN <i>MILLSBORO, SUSSEX, DEL.</i>							
24. FUNERAL DIRECTOR <i>Albright Nola</i>			25a. DATE REC'D. BY REGISTRAR <i>OCT 29 1980</i>			25b. REGISTRAR'S SIGNATURE <i>John H. Murphy</i>										

3

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 27038

1- STATE REGISTRAR		FIRST MIDDLE LAST		2a. DATE KNOWN OF ESTI. MONTH DAY YEAR		2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)		Keisha T. Collins		<input checked="" type="checkbox"/> 10 18 19 80		M		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 8 yrs.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR		2d. HOUR
female	Black	5 1 1972	8			10 18 19 80	12:50 P.M.	
11. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.		
Md		U.S.A.		Wicomico County				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury		Peninsula General Hospital						
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		14. STREET ADDRESS		
Md		Somerset	Westover	NO		Rt. 1-Bal. 278 Westover, Md		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
Everett C. Hill		Joyce P. Collins						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
(If Yes, Give War or Gates)						Joyce, P. Collins Rt. 1, Box 278, Westover		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR 3:40 P.M. 10/9 1980		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) pedestrian struck by Emergency Vehicle		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway		21f. LOCATION STREET State Rt 361 West of 4137 CITY OR TOWN County Wicomico, MD		STATE		
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Hormez R. Guard</i>		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 10/20/80		
EXAMINER'S NAME (TYPE OR PRINT)		Hormez R. Guard, M.D.		ADDRESS 111 Penn Street, Balto., MD 21201				
23a. BURIAL, CREMATION, REMOVAL		23b. DATE 10-25-80		23c. NAME OF CEMETERY OR CREMATORIAL St. James		23d. LOCATION CITY OR TOWN Westover, Somerset, Md		
24. FUNERAL DIRECTOR NAME Addie James, 407 Somerset Ave P2		ADDRESS Somerset, Md		25a. DATE REC'D. BY REGISTRAR OCT 31 1980		25b. REGISTRAR'S SIGNATURE Hormez R. Guard		
BP								
DHMH - 17 (VR A15 ME(5))								
15M 7/76								



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

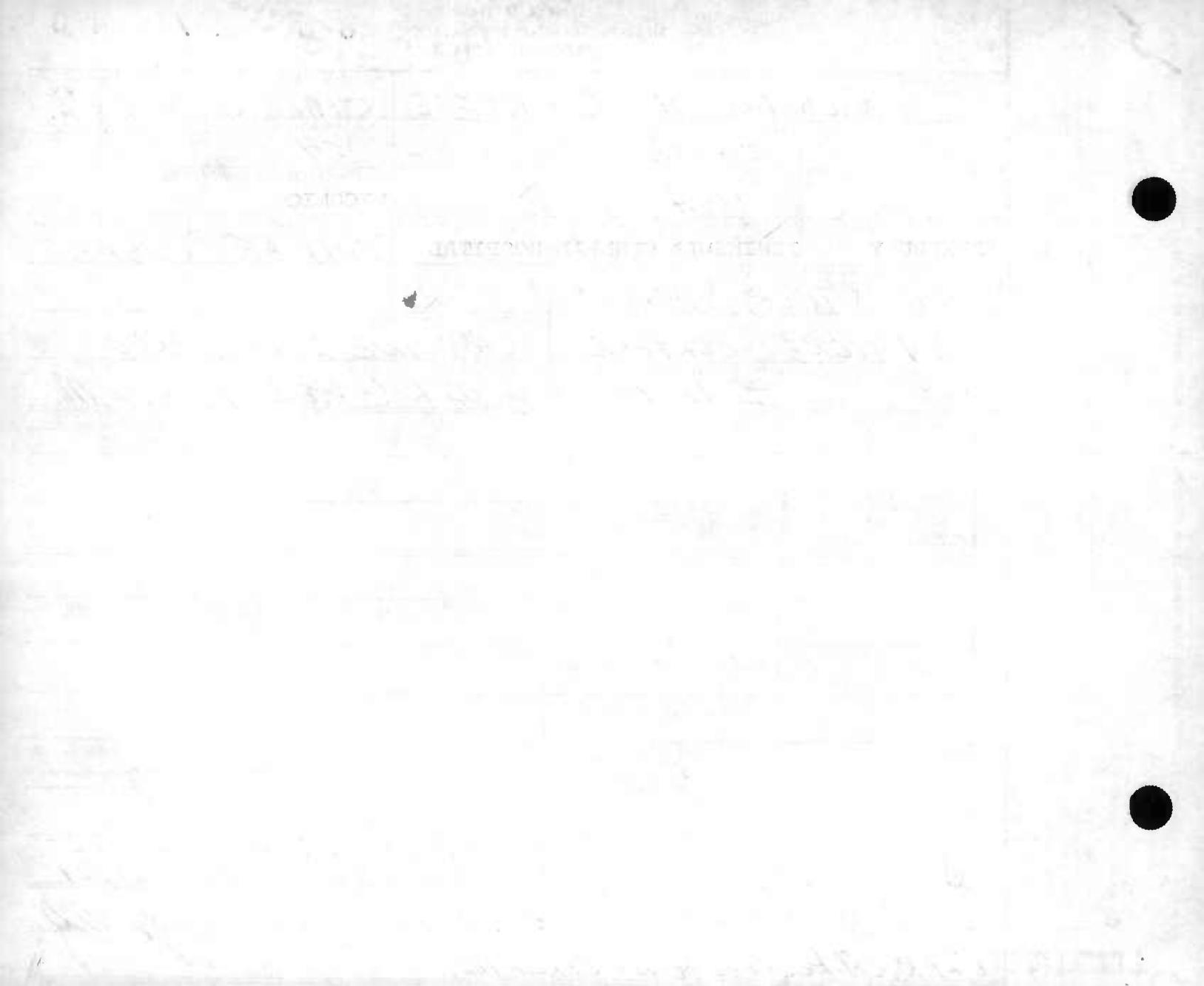
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 27039							
1- FOR STATE REGISTRAR			FIRST IDA			MIDDLE Selena			LAST CORBIN			2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH 10-1-80	DAY 19	YEAR 1980	2b. HOUR 1 P			
1. DECEASED NAME (TYPE OR PRINT)		3. SEX Female		4. RACE AA		5. DATE OF BIRTH MONTH 2 YEAR 19 DAY 17		6. AGE (IN YEARS) LAST BIRTHDAY 61 YRS.		7. IF UNDER 1 YR. MONTHS 0		8. IF UNDER 24 HRS. MONTHS 0		9. DATE PRONOUNCED DEAD 10-1-80		10. DATE MONT 19		11. HOUR 11 M	
7a. PLACE OF DEATH Snow Hill		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico		10. USUAL OCCUPATION (TYPE OF WORK) Domestic		11. KIND OF BUSINESS OR INDUSTRY MD.							
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 105 Evans Place		12a. USUAL OCCUPATION (TYPE OF WORK) FOR MOST OF WORKING LIFE		12b. KIND OF BUSINESS OR INDUSTRY													
13a. STATE Md.		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 105 Evans Place											
14. FATHER'S NAME Jesse		15. MOTHER'S MAIDEN NAME Corbin		16. SOCIAL SECURITY NO. 215-16-3548		17. INFORMANT Ruth Roberts		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. 215-16-3548		16c. ADDRESS Salisbury, Md.															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Right Lung 1629 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
22b. TITLE (SPECIFY) H.D. Deputy MEDICAL EXAMINER																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial																			
23b. DATE 10-4-80			23c. NAME OF CEMETERY OR CREMATORIUM Green Acres			24. LOCATION CITY OR TOWN Salisbury			25. COUNTY Wicomico			26. STATE Md.							
24. FUNERAL DIRECTOR NAME Jolley Funeral Home, Salisbury, Md.			25. DATE REC'D. BY REGISTRAR OCT 6 1980			26. REGISTRAR'S SIGNATURE R. Royer													
27. DHMH - 17 (VR A15 ME (5)) 15M 7/76																			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8027040				
REG. NO.																
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
			Nicholas A. CORTESE						OCTOBER 31 1980			4 P.M.				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALE			WHITE			MONTH DAY YEAR 9-24-26			54			MONTHS	YEARS	HOURS	MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
PA			USA			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			WICOMICO			MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
SALISBURY			PENINSULA GENERAL HOSPITAL			CARRIER			USPS							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS				
MD			WOR			BERLIN			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
SALVATORE			CAROLINE IADE MARCO			YES			160-20-077			Anna L. CORTESE - BERLIN, MD.			day year	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Stroke Central Thalamic</i>																
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Alzheimer's & other factors</i>																
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>old myocardial infarct</i>																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>10/20 1980</i> to <i>10/20 1980</i> , that (I) (we) last saw the deceased alive on <i>10/20 1980</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			LOCUST QUINCY STREET SALISBURY, MD. 21801										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE			
BURN			10-29-80			SUNSET M.P.			BERLIN, MD.							
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REG'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
ULRICH Federal Home - Berlin, MD.						OCT 31 1980										



TO HOSPITAL OR ATTENDING PHYSICIAN

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director for 72 hours after death. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic even

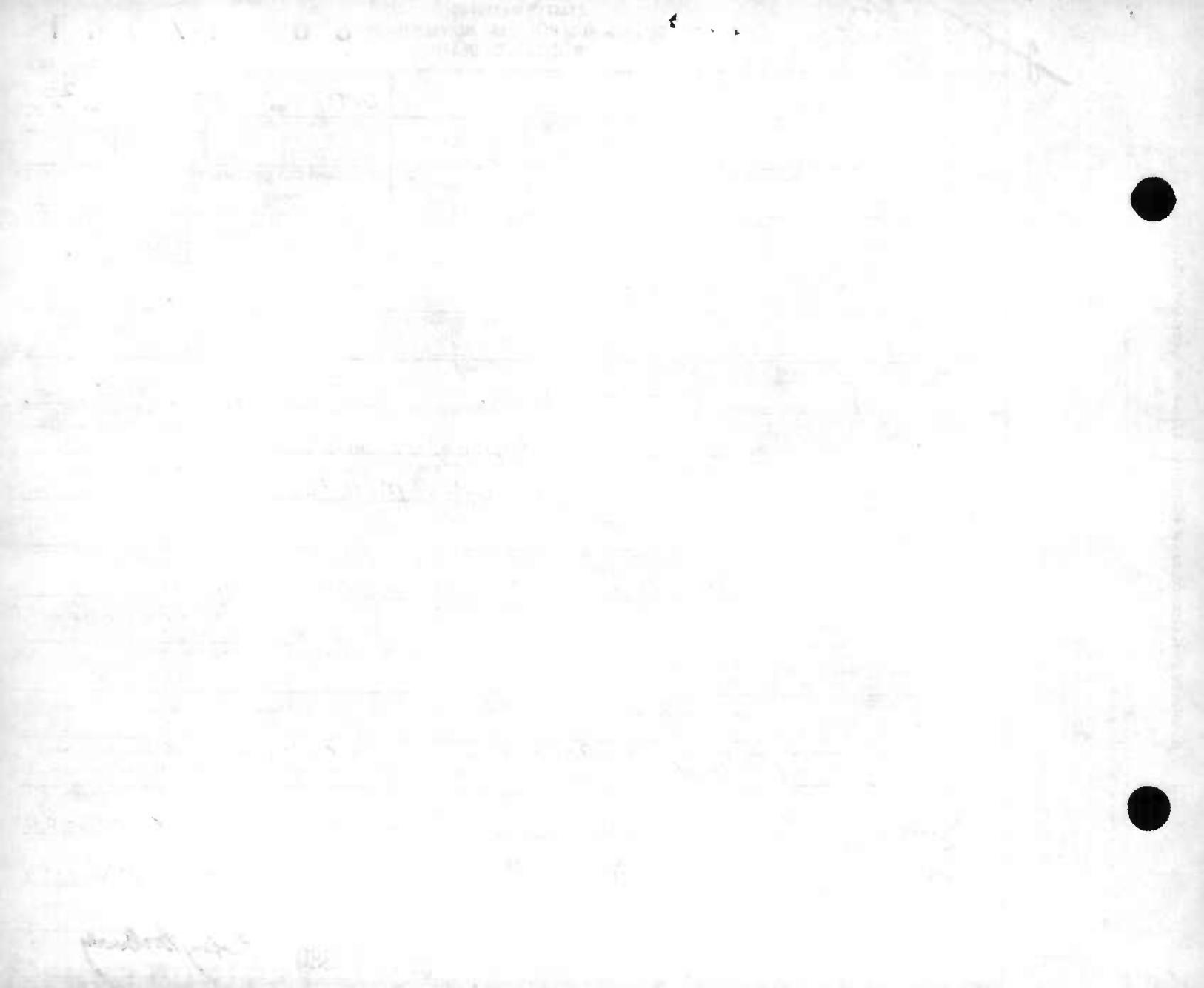
MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 27041

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Walter (Pat) Daisey			2a. DATE OF DEATH MONTH DAY YEAR Oct. 16 80			2b. HOUR 6 20 P.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 28, 1892	6. AGE (IN YEARS LAST BIRTHDAY) 88			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO		
10. CITY OR TOWN OF DEATH Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Salisbury Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman			12b. KIND OF BUSINESS OR INDUSTRY Power Co.
13a. STATE Maryland	13b. COUNTY Wicomico	13c. CITY OR TOWN Salisbury	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 129 Civic Ave.	
14. FATHER'S NAME FIRST William	MIDDLE Thomas	LAST Daisey	15. MOTHER'S MAIDEN NAME Elizabeth			LAST Cropper	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO 214-10-6059			17. INFORMANT (daughter) Mrs. Howard Thompson, Salisbury, MD			ADDRESS 215 Glen Ave.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes Mellitus Years.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(c) DUE TO, OR AS A CONSEQUENCE OF ASCVD & Diabetic Retinopathy & Senility							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from 9-12-80, 19, to 10-16-80, 19 80, that (I) (we) last saw the deceased alive on 10-16-80, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Joseph C. Fitzgerald M.D.		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-16-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph C. Fitzgerald M.D.		22e. ADDRESS Medical Center Salisbury Md 21801					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/19/80	23c. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Park			23d. LOCATION CITY OR TOWN Salisbury	23e. COUNTY	23f. STATE
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME,	ADDRESS Salisbury MD	25a. DATE REC'D. BY REGISTRAR OCT 20 1980					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 27042	REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR 10 15 A M
Herman			E.				Davis		October 15 1980				
3. SEX <i>Male</i>			4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 27, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 64		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Salisbury, Md.</i>			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico						
10. CITY OR TOWN OF DEATH <i>Salisbury</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Peninsula General Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>employee</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>market</i>						
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Wicomico</i>		13c. CITY OR TOWN <i>Salisbury</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 206 Gordy Road				
14. FATHER'S NAME FIRST <i>Raymond</i>			MIDDLE <i>P.</i>		LAST <i>Davis</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Gertrude</i>		MIDDLE <i>M.</i>		LAST <i>Godwin</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO <i>214-10-8681</i>		17. INFORMANT <i>Mrs. Anna M. Davis (wife)</i>		ADDRESS same as 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Renal Failure</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any (b) <i>small cell carcinoma of lung</i> (c) <i></i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <i>10/14</i> , 19 <i>80</i> , to <i>10/15</i> , 19 <i>80</i> , that (1) (we) lost saw the deceased alive on <i>10/15</i> , 19 <i>80</i> , and that in (my) <i>no</i> opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Joseph J. Grasso MD</i>			22c. DEGREE DEGREE					ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <i>10/15/80</i>			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Joseph J. Grasso</i>			22f. ADDRESS <i>Salisbury, Md.</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>10/17/80</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Springhill Memory Gardens, Salisbury, Wic., Maryland</i>			23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME <i>HOLLOWAY FUNERAL HOME</i>			25a. DATE REC'D. BY REGISTRAR <i>OCT 16 1980</i>					25b. REGISTRAR'S SIGNATURE <i>Patsy Bradley</i>					
ADDRESS <i>Salisbury, Md.</i>													

Re: Vets in Iraq

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 4.

1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

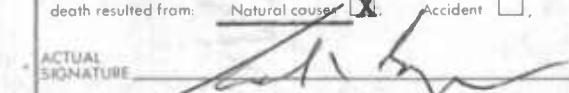
REG. NO.

8 0 2 7 0 4 3

1. DECEASED NAME (TYPE OR PRINT)			FIRST John	MIDDLE DIGENNARO	LAST	2a. DATE OF DEATH MONTH October	DAY 4, 1980	YEAR	2b. HOUR 8:40 a.m.
3. SEX Male		4. RACE White	5. DATE OF BIRTH MONTH 3 DAY 22 YEAR 1896		6. AGE (IN YEARS LAST BIRTHDAY) 84	IF UNDER 1 YEAR MONTHS YRS		IF UNDER 24 HRS HOURS 8 MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) U.S.A.		7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico				
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ref. Restaurant Owner	12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE NJ		13b. COUNTY Atlantic Margate		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 13 N. Clement Ave			
14. FATHER'S NAME FIRST Camille		MIDDLE D.J.	LAST Gennaro	15. MOTHER'S MAIDEN NAME Jophia		16. SOCIAL SECURITY NO. 175-28-3590		17. INFORMANT Rose Benedict, 521136uxy, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		probable brain stem CVA 4292							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b: organic brain syndrome									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Nancy W. Tustin, M.D.		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 10/4/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nancy W. Tustin, M.D.		22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entomment		23b. DATE 10/7/80		23c. NAME OF CEMETERY OR CREMATORIUM Queen of the Apostles Mausoleum		23d. LOCATION CITY OR TOWN Wilmington		STATE Del.	
24. FUNERAL DIRECTOR NAME CJ Messing, Bivalve, Md. 21814		25a. DATE REC'D. BY REGISTRAR OCT 10 1980 John M. Murphy							



X (3) 80 27044
 TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DAY IS NEEDED AND THE MEDICAL EXAMINER IS UNAVAILABLE, THIS CERTIFICATE SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3 FOR FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL/TRANSIT PERMIT. PAGES 1 AND 2 SHOULD NOT BE USED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL/CREMATION. OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTI- MATED			MONTH	DAY	YEAR	2b. HOUR				
JAMES			A		DOWDELL	10-7-80						P M				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD				
Male		AA		2 17 27		53 yrs.						10-7-80 19 4:45P				
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.						
FLA		U. S. A						Wicomico		WICOMICO						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Salisbury			328 Catherine St.								POULTRY					
13a. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. STATE		13c. COUNTY		13d. CITY OR TOWN		13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS					
			Md.		Wicomico		Salisbury				328 Catherine St.					
14. FATHER'S NAME			MIDDLE		LAST		15. MOTHER'S MAIDEN NAME									
ALBERT					DOWDELL		ELIZABETH			FOLKS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO			24538-2012		SALLY Milbourne			328 Catherine St.			years					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Status Epilepticus</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to the immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> (b) DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?				
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET						CITY OR TOWN				
												COUNTY		STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																
23a. ACTUAL SIGNATURE 													TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.													DATE SIGNED 10-9-80			
23b. BURIAL/CREMATION/REMOVAL (TYPE IF)			23b. DATE 10-11-80			23c. NAME OF CEMETERY OR CREMATORIAL ESTABLISHMENT St. Paul Cemetery						23d. COUNTRY Md.				
24. FUNERAL DIRECTOR NAME West-Fooks Funeral Home, Salisbury, Md.			ADDRESS OCT 14 1980			23e. DATE REC'D. BY REGISTRAR Oct 14 1980						23f. GASTRAS' SIGNATURE 				
BP																
DHMH - 17 (VR A15 ME(5))																
15M 7/76																

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-tranit permit. Then please remove carbon papers. Pages 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8027045					
												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
Leota Bee Duever						October 24, 1980						6:00 P.M.					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			# UNDER 1 YEAR		# UNDER 24 HRS					
Female		White		Sept. 20, 1913			67			YRS.	MONTHS	DAYS	HOURS	MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.							
S. Dakota		USA					Wicomico										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury		Peninsula General Hospital										Civil service Emp.			Air Force		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			13f. ADDRESS					
Maryland		Wicomico		Salisbury					129 May Drive			same as 13					
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST								
Fred			W.	Rucker	Bessie					Fauver							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
NO			508-32-4142			Mr. John T. Duever (husband)											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
492- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost												10 yrs.					
DUE TO, OR AS A CONSEQUENCE OF (b)																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cancer of larynx.																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE					
22a. I certify that (I) this hospital attended the deceased from 1976, 19, to 10/24, 1980, shot (I) was lost saw the deceased alive on 10/24, 1980, and that in my (we) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (our) did not view the body after death.												22c. DATE SIGNED 10/24/80					
22b. SIGNATURE Layton			22c. DEGREE M			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			PGHMC, 100 E. Carroll St., Salisbury, Maryland											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/30/80			23c. NAME OF CEMETERY OR CREMATORIUM Arlington National Cem.			23d. LOCATION CITY OR TOWN Ft. Myers			COUNTY	STATE				
24. FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME, Salisbury, Maryland			ADDRESS			25a. DATE REC'D. BY REGISTRAR OCT 27 1980			25b. REGISTRAR'S SIGNATURE			Virginia					

BP

DHMH-16 25M
(VRA 15, 4) 1/79

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										0	2	7	0	4	6		
										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST Ralph			MIDDLE W.			LAST Dukes			2a. DATE OF DEATH 10/2/80			2b. HOUR 1100PM		
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR Aug. 30, 1896			6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS			7. IF UNDER 1 YEAR MONTHS DAYS			8. IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. BALTIMORE CITY OR COUNTY OF DEATH Wicomico			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico			10. CITY OR TOWN OF DEATH Pittsville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Melson RD.		
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			12b. KIND OF BUSINESS OR INDUSTRY Agriculture			13a. STREET ADDRESS Melson Road			13b. CITY OR TOWN Pittsville			13c. COUNTY Wicomico			14. FATHER'S NAME First Will		
15a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			15b. SOCIAL SECURITY NO. 216-14-9538			16. INFORMANT Mrs. Jean Miles, Salisbury, MD			17. ADDRESS			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hrs.			19. MOTHER'S MAIDEN NAME Louisa J. Dukes		
19. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			20. DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis -			21. DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Alcoholism																	
22a. DATE OF OPERATION			22b. CONDITION FOR WHICH OPERATION WAS PERFORMED			22c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			22d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
22e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			22f. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			22g. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
22h. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			22i. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			22j. LOCATION STREET CITY OR TOWN COUNTY STATE											
22k. I certify that (I) this hospital attended the deceased from 11/3/1979 to 10-7-1980, that (I) (we) last saw the deceased alive 4/21/1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22l. SIGNATURE Roger C. Merrill															22m. DEGREE MD		
22n. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22o. DATE SIGNED 10-3-80														
22p. PHYSICIAN'S NAME (TYPE OR PRINT) Roger C. Merrill			22q. ADDRESS Kay Drive, Salisbury, MD														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/5/80			23c. NAME OF CEMETERY OR CREMATORIAL Pittsville Cemetery			23d. LOCATION CITY OR TOWN Pittsville COUNTY Wic STATE MD								
24. FUNERAL DIRECTOR NAME Watson & Whaley, Selbyville, DE			25a. DATE REC'D. BY REGISTRAR OCT 8 1980			25b. REGISTRAR'S SIGNATURE Roger C. Merrill											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					30 27047
					REG. NO.
1. DECEASED NAME (TYPE OR PRINT)	FIRST Eva	MIDDLE B.	LAST ELLIOTT	2a. DATE OF DEATH OCTOBER 27, 1980	2b. HOUR 9 1/2 M
3. SEX Female	4. RACE Cauc.	5. DATE OF BIRTH Sept 5, 1901	6. AGE (IN YEARS LAST BIRTHDAY) 79	7. IF UNDER 1 YEAR YRS.	
7a. BIRTHPLACE COUNTRY Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO	10. IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
10. CITY OR TOWN OF DEATH Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical	12b. KIND OF BUSINESS OR INDUSTRY Insurance	13. MD.	
13a. STATE Delaware	13b. COUNTY Sussex	13c. CITY OR TOWN Laurel	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 214 Lewis Drive	
14. FATHER'S NAME FIRST King	MIDDLE Bethard	15. MOTHER'S MAIDEN NAME Lillian	POLLITT	16. ADDRESS Salisbury, Maryland 1104 Riverside Dr. 21801	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. 213 10 8944	17. INFORMANT Dr. Richard Reddish	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute hypertensive Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia Rt lower lobe</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic carcinoma probably breast</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (his hospital) attended the deceased from <u>10-27-1980</u> to <u>10-27-1980</u> that (I) (we) last saw the deceased alive on <u>10-27-1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>James A. Clifford MD</i>	DEGREE	22c. DATE SIGNED 10/29/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James A. Clifford MD	22e. ADDRESS #12 Medical Center Salisbury, Md				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b. DATE 10/30/80	23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery	23d. LOCATION CITY OR TOWN Baltimore	COUNTY	STATE Maryland
24. FUNERAL DIRECTOR NAME Homer L. Disharoon box 678 Laurel Del	ADDRESS 19956	25a. DATE REC'D. BY REGISTRAR NOV 3 1980	25b. REGISTRAR'S SIGNATURE <i>Hector McCreary</i>		

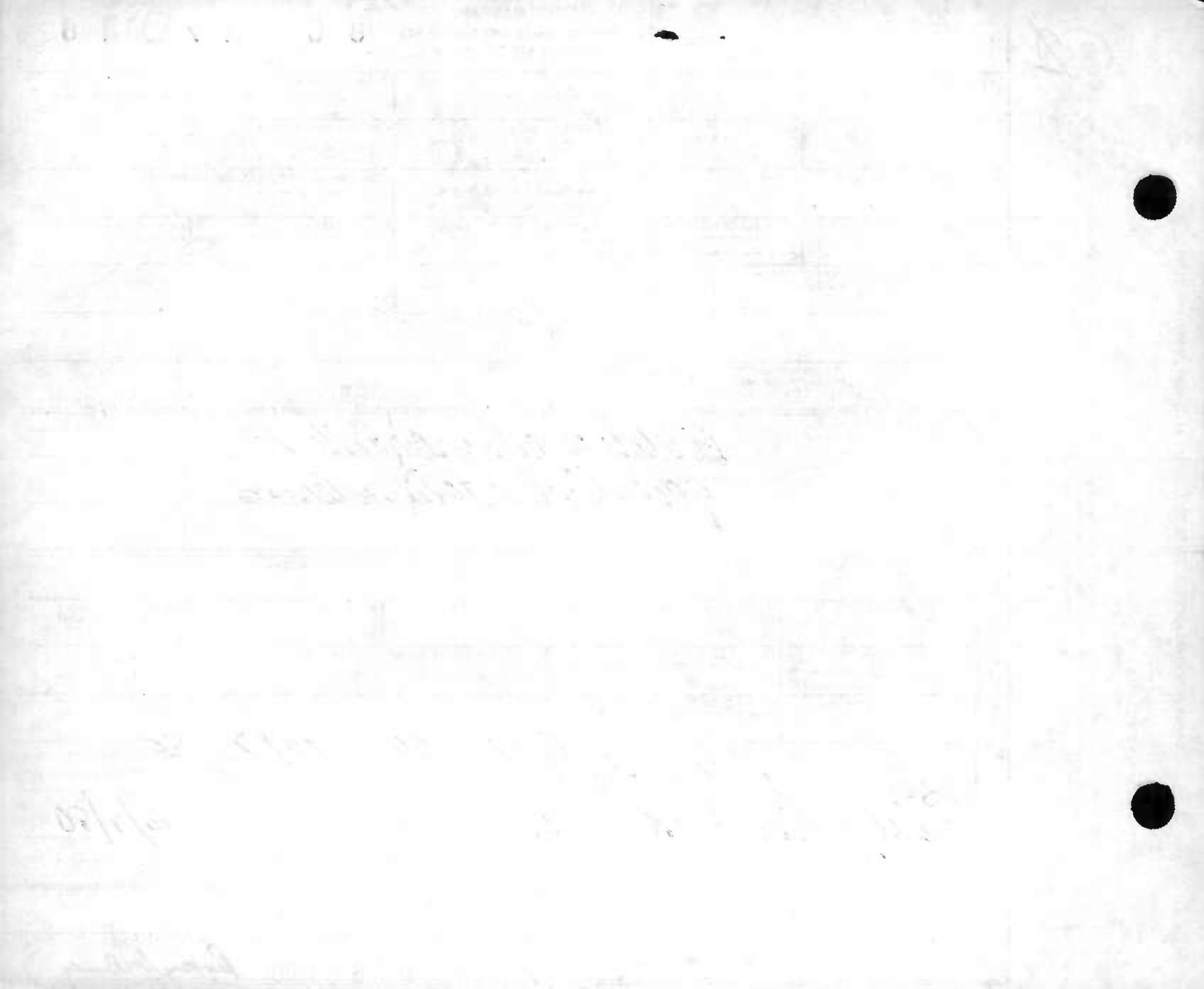
1886-1890

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8027048	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
ARTHUR			Carlton	ENGLISH		10--02-1980				1:30	a		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		Sept. 17, 1892		88		MONTHS DAYS		HOURS MIN			
YRS													
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Riverton, Md.		USA				WICOMICO							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Salisbury		SALISBURY NURSING HOME		Retired Restaurant owner									
13a. STATE 13b. COUNTY Maryland Wicomico												13c. CITY OR TOWN Salisbury	
13d. INSIDE CITY LIMITS?		YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 116 Saratoga St.									
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST					
Wesley		Thomas		Dora						Russell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS							
Yes WW I				Mrs. Maxine Kellum, 286 Sussex Road (daughter)		Ocean City, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b) and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a):												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.													
DUE TO, OR AS A CONSEQUENCE OF (b): <i>arterial vascular accident</i> <i>generalized arterial occlusion</i>													
DUE TO, OR AS A CONSEQUENCE OF (c):													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
19b. YES <input type="checkbox"/> NO <input type="checkbox"/>						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (1) this hospital attended the deceased from <u>8/27/80</u> to <u>10/2/80</u> , that (1) (we) lost saw the deceased alive on <u>8/27/80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.												22c. DATE SIGNED <u>10/1/80</u>	
22b. SIGNATURE <i>Earl M. Beardsley</i>		22c. DEGREE <i>M.D.</i>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22e. PHYSICIAN'S NAME (TYPE OR PRINT) EARL M. BEARDSLEY, M.D.		22f. ADDRESS U.S. 50 AT CIVIC AVE., SALISBURY, MD. 21801											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/4/80		23c. NAME OF CEMETERY OR CREMATORIAL Wicomico Mem. Park		23d. LOCATION CITY OR TOWN Salisbury, Wic.		COUNTY		STATE Maryland			
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury		ADDRESS		25a. DATE REC'D. BY REGISTRAR OCT 6 1980		25b. REGISTRAR'S SIGNATURE <i>Henry McCrady</i>							
BP													
DHMH-16 25M (VRA 15, 4) 1/79													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30 27049

1. DECEASED NAME (TYPE OR PRINT)			FIRST Arthur	MIDDLE James	LAST ENNIS	2a. DATE OF DEATH MONTH OCTOBER DAY 16, 1980	YEAR 1980	2b. HOUR 12 '8 M		
3. SEX Male			4. RACE White	5. DATE OF BIRTH MONTH Oct. 19, 1908 DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico				
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Peninsula General Hospital			12a. USUAL OCCUPATION retired employee			12b. KIND OF BUSINESS OR INDUSTRY -Food Pro.	
13a. STATE Maryland			13b. COUNTY Wicomico		13c. CITY OR TOWN Fruitland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS BOX 97, 211 Holly St.	
14. FATHER'S NAME FIRST William			MIDDLE James	LAST Ennis	15. MOTHER'S MAIDEN NAME Lillie Mae			16. ADDRESS 211 Holly St.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) (unknown) 217-07-1619			17. INFORMANT (sister) Mrs. Beulah E. Pennewell, Fruitland, Md			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 486- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						Congenital Heart Failure				
DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Central Nervous Sys. (hemiplegia; sensory disorders)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (his hospital) attended the deceased from 10/10/69 to 10/10/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated saw the deceased alive on 10/10/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 10/16/80
22b. SIGNATURE Helen M. Baldado MD			22d. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) HELEN M. BALDADO MD.			22f. ADDRESS 547 F. RIVERSIDE DR. SALISBURY, MD 21801							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/18/80			23c. NAME OF CEMETERY OR CREMATORIAL Union Church Cem.			23d. LOCATION CITY OR TOWN Wic., Maryland	
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md.			25a. DATE REC'D. BY REGISTRAR OCT 20 1980			25b. REGISTRAR'S SIGNATURE Holloway				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 3027050				
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			Oct. 2, 1980			9:30 A.M.				
(Baby Boy)			Evans													
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
Male			White			Oct. 2, 1980			0			26				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. IF UNDER 24 HRS MONTHS DAYS HOURS MIN.				
Salisbury, Md.			USA						Wicomico							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury			Peninsula General Hospital									none			none	
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
Maryland			Wicomico			Salisbury			YES			142 S. Kaywood Drive				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST													
Thomas Hugh Evans			Maria									Barney				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.									17. INFORMANT ADDRESS				
NO												Mr. Thomas H. Evans (father)			same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
7531 Cardio. Respiratory failure																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																
DUE TO, OR AS A CONSEQUENCE OF (b)																
Alelectatic Lung.																
DUE TO, OR AS A CONSEQUENCE OF (c)																
Multcystic kidney.																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)										
			P.M. 19													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 10/2, 1980, to 10/2, 1980, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE			DEGREE									22c. DATE SIGNED				
Bry. Lata Agorwal MD												10/2/80.				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS													
			Salisbury, Maryland													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			COUNTY		STATE		
Burial			10/4/80			Wicomico Mem.			Park			Salisbury		Wic.		
24. FUNERAL DIRECTOR NAME			ADDRESS									25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE	
HOLLOWAY FUNERAL HOME, Salisbury, Md.												OCT 8 1980			Holloway	

school

Education Dept. 10th Street, Philadelphia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										30 27051			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>Edith Carstens</i>										2a. DATE OF DEATH <i>10-26-80</i>			
3. SEX <i>Female</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH MONTH <i>Jan.</i> DAY <i>4.</i> YEAR <i>1916</i>		6. AGE (IN YEARS LAST BIRTHDAY) 64		7. IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>		8. IF UNDER 24 HRS HOURS <i>9</i> MIN. <i>05</i>			
7a. BIRTHPLACE <i>New York</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Wicomico</i>		10. USUAL OCCUPATION <i>Teaching 1st Public School</i>					
10. CITY OR TOWN OF DEATH <i>Salisbury</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <i>Peninsula General Hospital</i>		12. STREET ADDRESS <i>205 Woburnest Ave</i>		13. CITY OR TOWN <i>Wicomico</i>							
13. STATE <i>Md.</i>		13b. COUNTY <i>Wicomico</i>		13c. CITY OR TOWN <i>Salisbury</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>205 Woburnest Ave</i>					
14. FATHER'S NAME <i>ALFRED</i>		15. MOTHER'S MAIDEN NAME <i>Florence</i>		16. SOCIAL SECURITY NO. <i>065-09-3540</i>		17. INFORMANT <i>Thomas K. Evans</i>		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF NO UNKNOWN) <i>No</i>		16b. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Embolus</i>		16c. DUE TO, OR AS A CONSEQUENCE OF (b) <i>emphysema</i> <i>no lung cancer (active)</i>		16d. DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (1) <i>this hospital</i> attended the deceased from <i>10/13</i> , 19 <i>80</i> , to <i>10/26</i> , 19 <i>80</i> , that (1) <i>we</i> lost saw the deceased alive on <i>10/26</i> , 19 <i>80</i> , and that in (my) <i>we</i> opinion death occurred on the date and hour and from the causes stated above. (1) <i>we</i> (did) <i>did not</i> view the body after death.													
22b. SIGNATURE <i>Joseph A. Grasso</i>		22c. DEGREE <i>MD</i>		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <i>10-26-80</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Joseph A. Grasso</i>		22e. ADDRESS <i>1300 S. Division St. Salisbury Md. 21801</i>											
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <i>Burial</i>		23b. DATE <i>10/29/80</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Spring Hill Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Salisbury</i>		23e. COUNTY <i>Md.</i>					
24. FUNERAL DIRECTOR NAME <i>Hill-Basket-Bowards</i>		25a. ADDRESS <i>Salisbury Md.</i>		25b. DATE REC'D. BY REGISTRAR <i>OCT 31 1980</i>		25c. REGISTRAR'S SIGNATURE <i>Patty K. Barnes</i>							

Indirectly influenced

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign and completely fill in by the funeral director.

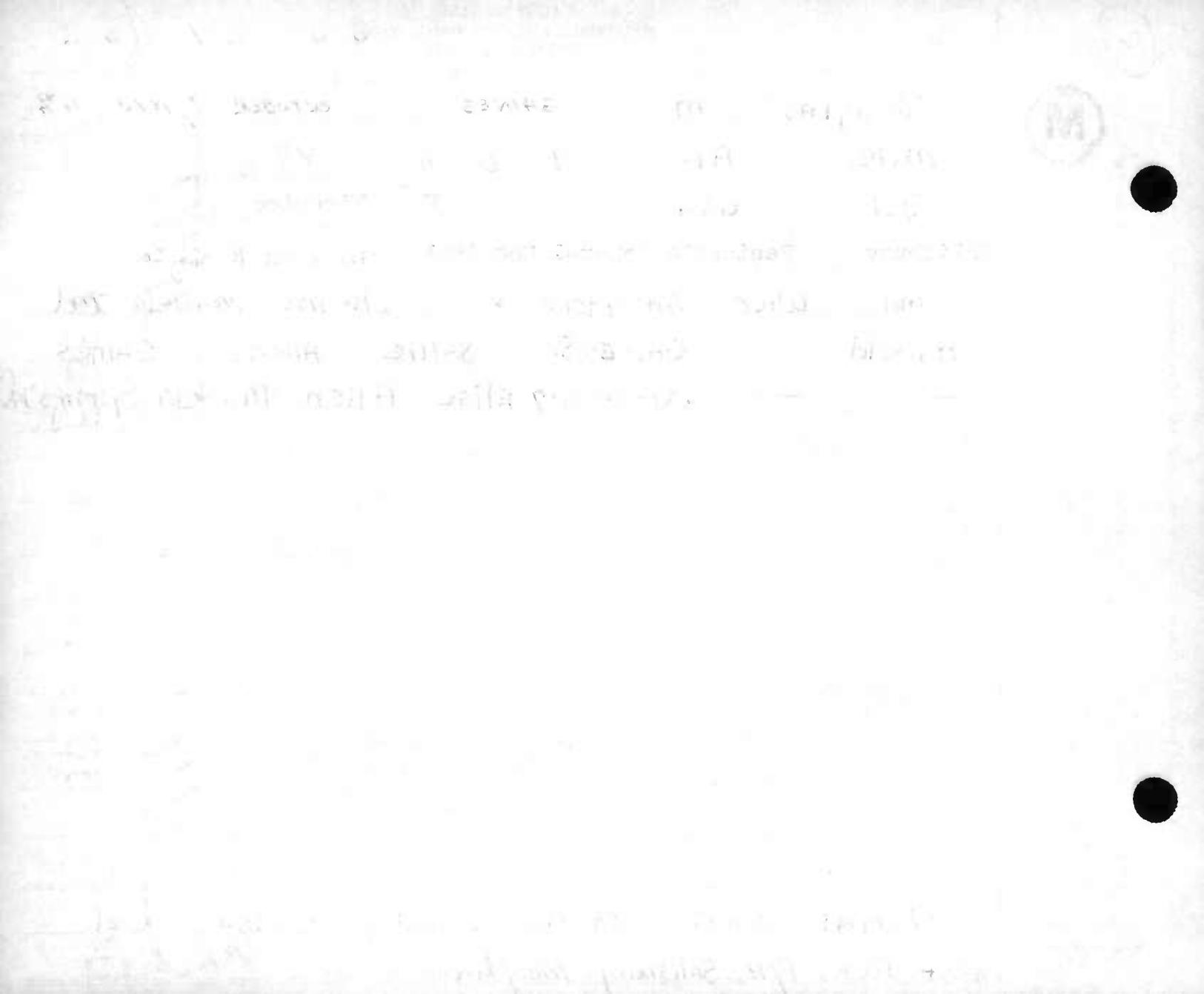
referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8027052								
												REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Douglas			m			GAINES						OCTOBER			7	1980		11 AM		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS					
male			AA			MONTH 9 DAY 6 YEAR 31			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			MONTHS 49 YRS			MONTHS 0 DAYS HOURS 0 MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH					
Del			USA									Wicomico			Salisbury					
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			13a. STATE			13b. COUNTY			13c. CITY OR TOWN			12b. KIND OF BUSINESS OR INDUSTRY					
Peninsula General Hospital			maverick Packing Co.			Md			Wico			Sharptown								
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Harold			Sallie Allen Gaines			—			—			221-18-3447			Elise Allen Mandela Springs			acidosis		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (his hospital) attended the deceased from Oct. 10, 1980, to Oct. 7, 1980, that (I) (we) lost saw the deceased alive on Oct. 7, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE Rodney A. WENRICH MD			22c. DEGREE DEGREE			22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS KAY AVE. SALISBURY MD 21801			22f. DATE SIGNED 10/11/80					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 10-11-80			23c. NAME OF CEMETERY OR CREMATORIAL Mt. Nebo Cemetery Columbia			23d. LOCATION CITY OR TOWN			23e. COUNTY Del.			24. FUNERAL DIRECTOR NAME West Foothills F/H, Salisbury, Maryland					
25a. DATE REC'D. BY REGISTRAR OCT 14 1980			25b. REGISTRAR'S SIGNATURE Lisa J. [Signature]																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be attached to this page. If the funeral director, page 3, should be detached for use as the burial-transit permit, then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 00 27053				
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR									2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
John			Joseph Grim			Feb. 4, 1923			57			MONTHS		DAYS		
1. SEX Male			4. RACE White			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH WICOMICO			MD.	
10 CITY OR TOWN OF DEATH Parsonsburg			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 2			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) owner - Auto dealership			12b KIND OF BUSINESS OR INDUSTRY							
13 STATE Maryland			13b COUNTY Wicomico			13c CITY OR TOWN Parsonsburg			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS Rt. 2, Box 265				
14 FATHER'S NAME John FIRST A. MIDDLE LAST			15. MOTHER'S MAIDEN NAME Emma FIRST C. MIDDLE LAST Stevens													
16a WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO OR UNKNOWN Yes			16b SOCIAL SECURITY NO. WW II 138-18-2238			17 INFORMANT Mrs. Dawn J. Grim (wife) same as 13			ADDRESS							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Malignant Melanoma</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
<u>1729</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																
(b) DUE TO, OR AS A CONSEQUENCE OF																
(c) DUE TO, OR AS A CONSEQUENCE OF																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (His hospital) attended the deceased from <u>10/10/86</u> to <u>00/16/86</u> , that (I) (we) last saw the deceased alive on <u>10/10/86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 10/20/80				
22b. SIGNATURE <u>Grasso</u>			DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph A. Grasso, M.D.			22e ADDRESS 1300 S. Division St., Salisbury, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 10/18/80			23c. NAME OF CEMETERY OR CREMATORIAL Delmarva Crematory			23d. LOCATION CITY OR TOWN Lewes, Sussex, Delaware			COUNTY	STATE			
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salsisbury, Md.			ADDRESS			25a. DATE REC'D. BY REGISTRAR Oct 21 1980			25b. REGISTRAR'S SIGNATURE <u>Holloway</u>							

M

Under way

0921 13 130

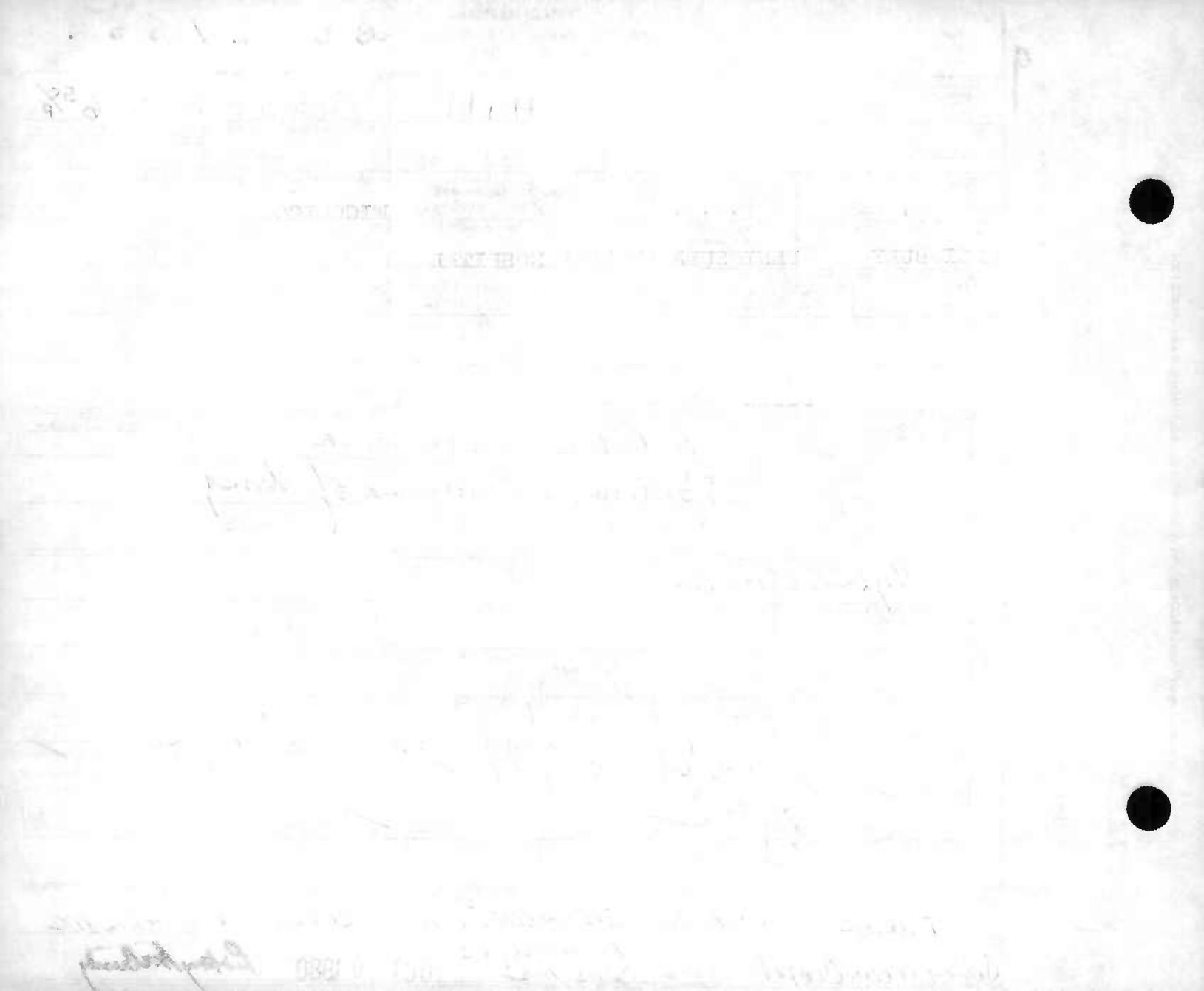
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please stamp the



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, item 1 and 2 should be removed carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												6 0 2 7 0 5 4								
												REG. NO.								
1 - STATE REGISTRAR			I DECEASED NAME (TYPE OR PRINT)			FIRST DAISEY			MIDDLE AYRES			LAST Hall			2a. DATE OF DEATH October 14, 1980			2b. HOUR 6 59 PM		
3. SEX FEMALE			4. RACE BLACK			5. DATE OF BIRTH MONTH DAY YEAR 4 25 22			6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS			7a. DATE OF DEATH October 14, 1980			7b. MONTH MONTHS DAYS HOURS MIN					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEWARK, MD			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			7c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			7d. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD.											
10. CITY OR TOWN OF DEATH SALISBURY			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PENINSULA GENERAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER			12b. KIND OF BUSINESS OR INDUSTRY POULTRY											
13a. STATE MD			13b. COUNTY WICOMICO			13c. CITY OR TOWN BERLIN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS FLOWER STREET								
14. FATHER'S NAME FIRST TSSAC			MIDDLE AYRES			15. MOTHER'S MAIDEN NAME FIRST SARAH			MIDDLE			LAST FOREMAN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO 215-20-0394			17. INFORMANT CHARLES HALL			ADDRESS SAME AS ABOVE			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1629 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost												The last stage Carcinoma due to, or as a consequence of, (b) <i>epidermoid Carcinoma of lung</i> due to, or as a consequence of (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1629 1629 Hypoxia																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IN EITHER, HOSPITAL MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
22a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 9/9/80			22c. LOCATION STREET CITY OR TOWN 9/9/80 10/14/80			22d. COUNTY 80			22e. STATE								
22f. I certify that (i) (this hospital) attended the deceased from saw the deceased alive on above, (ii) (we) did (did not) view the body after death.												22g. DATE SIGNED 10/14/80								
22h. SIGNATURE <i>John H. B. Hall</i>												22i. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22j. PHYSICIAN'S NAME (TYPE OR PRINT) John H. B. Hall												22k. ADDRESS Berlin Worcester, MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10-18-80			23c. NAME OF CEMETERY OR CREMATORIAL Evergreen Cem			23d. LOCATION CITY OR TOWN Berlin COUNTY Worcester STATE MD											
24. FUNERAL DIRECTOR NAME Jockey Mem. Chapel			ADDRESS Rt. 2 Jersey Rd Salis. MD			25a. DATE REC'D. BY REGISTRAR OCT 20 1980			25b. REGISTRAR'S SIGNATURE <i>John H. B. Hall</i>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, issue 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 30 27055						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Jerome Henry									Harmon			October 25, 1980					5 40 PM	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS				
Male			Caucasian			Jan 18, 1908			72			MONTHS		DAYS		HOURS		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			10. CITIZEN OF WHAT COUNTRY?			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Md.			U.S.A.			PENINSULA GENERAL HOSPITAL			Real Estate Mgr. Rental Property			Golf Course Rd. Rt 1, Box 413						
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS						
Md.			Worcester			Ocean City			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Golf Course Rd. Rt 1, Box 413						
14. FATHER'S NAME			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME			ADDRESS						
Zadok			—			Holstan			Amelia			Frances M. Tarr 32 Burley St. Berlin, Md.						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
No			220-12-2121						Congestive Heart Failure									
4292			Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) Arteriosclerotic Cardio Vascular Disease			(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from 10/23/80 to 10/25/80, that (I) (we) last saw the deceased alive on 10/25/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED									
Oswald J. Burton, MD									10/25/80									
22e. ADDRESS																		
Kay Ave., Salisbury, Maryland 21801																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			COUNTY		STATE				
Burial			10/28/80			Evergreen Cemetery			Berlin			Wor.		Md.				
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
Anna J. Burton, 108 Williams St. Berlin, Md.						OCT 31 1980			Burke McCloud									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Please do so.

RECEIVED

M

15

BP

DHMH-16 25M
(VRA 15, 4) 1/791. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

30 27056

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Anna ALVERTA					Hannigan	October 3, 1980				15	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
FEMALE		WHITE		JULY 27, 1908		72		YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. KIND OF BUSINESS OR INDUSTRY			
PENNA.		USA.				WICOMICO		OWN HOME			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
SALISBURY		PENINSULA GENERAL HOSPITAL		HOUSEWIFE							
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STREET ADDRESS					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		E5 WALSTON'S TRAILER PARK					
MARYLAND		WICOMICO		SALISBURY							
14. FATHER'S NAME		FIRST	MIDDLE	LAST	13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
GEORGE WASHINGTON BROWN					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E5 WALSTON'S TRAILER PARK				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO		212-40-7669		JAMES P. MOYER (SON)		1 day					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY						19. IMMEDIATE CAUSE (a)				20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						Cardiac (or) Failure				1 day	
19. DUE TO, OR AS A CONSEQUENCE OF (b) Death preceded by										Dey	
19. DUE TO, OR AS A CONSEQUENCE OF (c) Other death preceded by										1 day	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
21a. MEDICAL CERTIFICATION		20a. DATE OF OPERATION		20b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20c. AUTOPSY?		20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21f. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21g. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21h. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21i. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21j. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10/12/80, to 10/13/80, that (I) (we) last saw the deceased alive on 10/13/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John G. Green						DEGREE					
22c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22d. DATE SIGNED 10/31/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS 400 S. QUINCY ST SALISBURY MARYLAND 21801					
JOHN G. GREEN M.D.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		COUNTRY		STATE	
BURIAL		OCT 6, 1980		ODD FELLOWS CEM.		SEAFORD SUSSEX DELAWARE					
24. FUNERAL DIRECTOR NAME Paymer M. WATSON - SEAFORD, DELAWARE 19973						25a. DATE REC'D. BY TELEGRAPH 75b. DATE REC'D. BY CEMETERY					

N

0001 0100

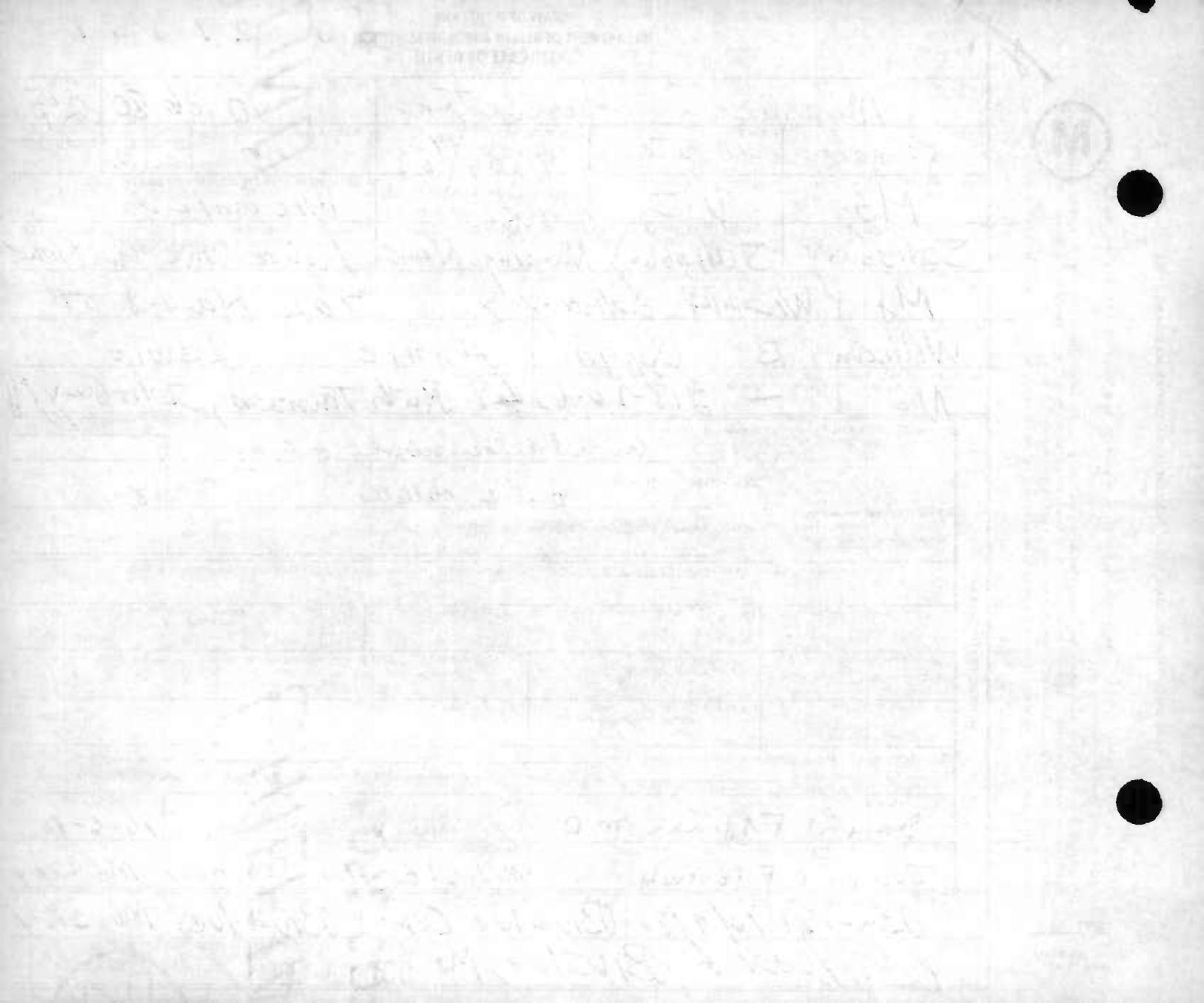
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, if referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at office.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 27057						
1 - FOR STATE REGISTRAR		REG. NO.														
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE		LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Minnie							Harrington			10	06	80		25		
3. SEX Female		4 RACE white			5. DATE OF BIRTH MONTH		YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			7			19			77		MONTHS 2		DAYS 2	
Md.		U.S.			MARRIED <input type="checkbox"/>			NEVER MARRIED <input type="checkbox"/>			YRS.		HOURS		MIN.	
WIDOWED <input checked="" type="checkbox"/>		DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico		MD.									
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Wife Own Home											
13a. STATE MD		13b. CITY OR TOWN Wicomico			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/>		13e. STREET ADDRESS 702 Howard St			12b. KIND OF BUSINESS OR INDUSTRY						
14. FATHER'S NAME William		15. MOTHER'S MAIDEN NAME Annie			16. SOCIAL SECURITY NO 218-20-6248		17. INFORMANT Ruth Townsend, Salisbury, Md.		ADDRESS		APPROXIMATE (ESTIMATED) BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO, OR AS A CONSEQUENCE OF (b) Diseases Mellitus			DUE TO, OR AS A CONSEQUENCE OF (c)						yes					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE Joseph C. Fitzgerald M.D.		DEGREE			ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22c. DATE SIGNED 10-6-80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph C. Fitzgerald					22e. ADDRESS Medical Center Salisbury, Md. 2184											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/9/80			23c. NAME OF CEMETERY OR CREMATORIAL Bivalve Cem.		23d. LOCATION CITY OR TOWN Bivalve, Md. 2184		COUNTY		STATE					
24. FUNERAL DIRECTOR NAME Joseph C. Fitzgerald		ADDRESS Bivalve, Md.			25a. DATE REC'D. BY REGISTRAR OCT 10 1980		25b. REGISTRAR'S SIGNATURE Patsy McCreedy									



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW. RETAIN PAGE 3 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

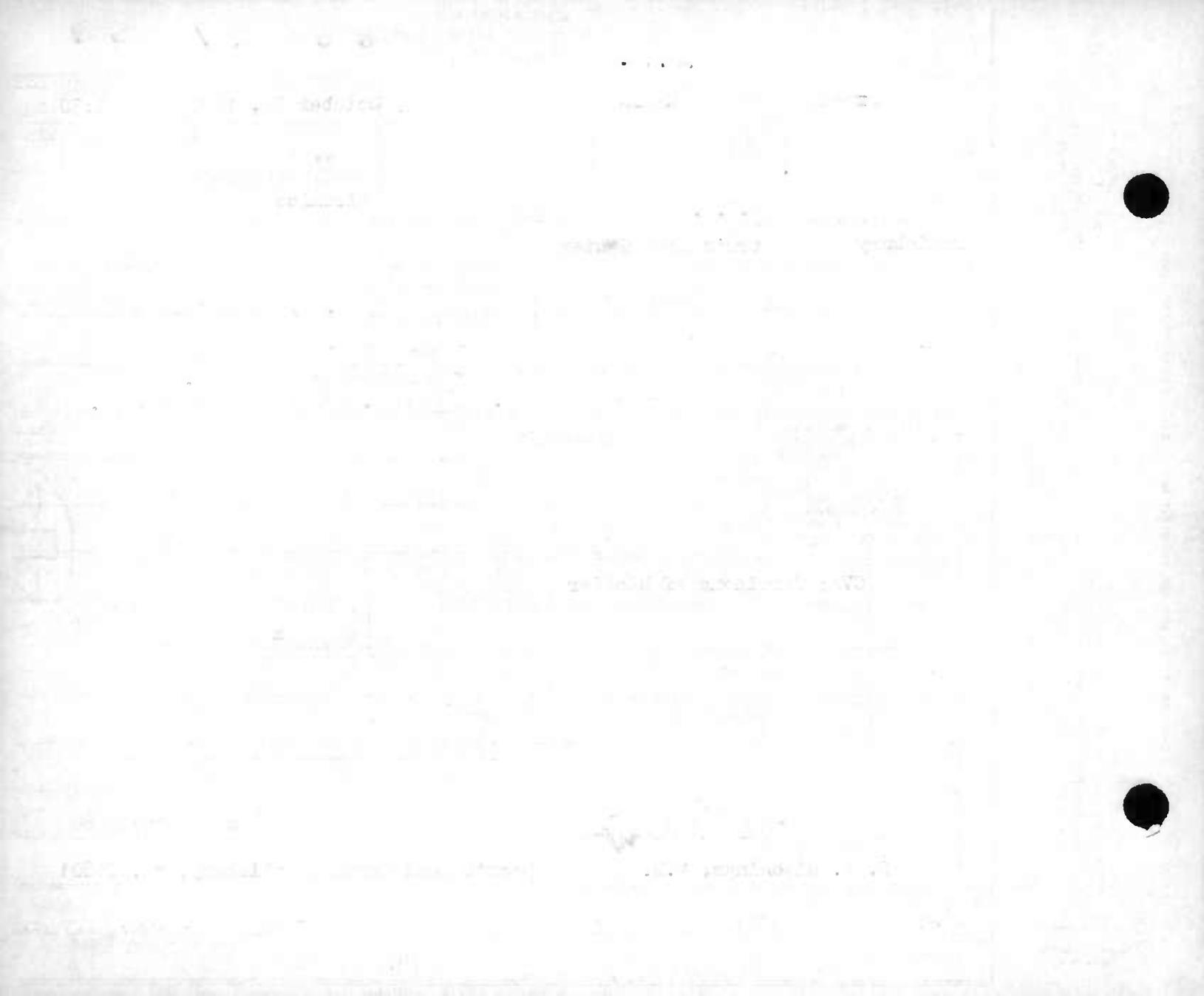
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 27058			
1- STATE REGISTRAR			2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 10-12-80									2b. HOUR 6P M			
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST						
Eldridge			Harold			Hastings									
3 SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.		IF UNDER 24 HRS.									
Male	White	Nov. 1, 1909	70 yrs.	MONTHS	DAYS	HOURS	MIN.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Salisbury, Md.			USA						Wicomico						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY
Salisbury			301 E. College Ave.									Foreman-Concrete, Bldg. Material			
13a. STATE Maryland			13b. COUNTY Wicomico			13c. CITY OR TOWN Salisbury			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 301 E. College Ave.			
14. FATHER'S NAME FIRST Harold			MIDDLE			LAST Hastings			15. MOTHER'S MAIDEN NAME FIRST Blanche			LAST Brittingham			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS						
No			214-10-6871A			Mr. & Mrs. M. L. Bradley, Salisbury, Md.			405 Washington St.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410 Conditions, if any, which gove rise to immediate cause (a) stating the under- lying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden			
IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF ASCVD (b) DUE TO, OR AS A CONSEQUENCE OF (c)												years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												and in my opinion			
22b. TITLE (SPECIFY) M.D. Deputy												MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.												ADDRESS 409 Camden Ave., Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/15/80			23c. NAME OF CEMETERY OR CREMATORIAL Springhill Memory Gardens, Salisb., Wic., Maryland			23d. LOCATION CITY OR TOWN			COUNTY STATE			
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Maryland			ADDRESS			25a. DATE REC'D. BY REGISTRAR OCT 15 1980			25b. REGISTRAR'S SIGNATURE L. Royer, M.D.						
DHMH - 17 (VR A15 ME (5)) 30M 7/73															

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										0 27059					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR EST						
Ernest Lee HEARN						October 26, 1980			2:30 a.m.						
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9/30/1899			81 yrs.								
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico													
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Deer's Head Center								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Herdsman		12b. KIND OF BUSINESS OR INDUSTRY Dairy			
13a. STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Parsonsburg			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Rt. 1, Sixty Foot Road					
14. FATHER'S NAME FIRST MIDDLE LAST Asher Lee Hearn		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Aloma (Allie) Perdue													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-10-9513								17. INFORMANT (brother-in-law) ADDRESS Mr. William J. Bull, Parsonsburg, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4860												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b)															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CVA; Carcinoma of bladder															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>Ernest Lee Hearn</i>		22c. DEGREE								ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. P. Ritchings, M.D.		22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801								22f. DATE SIGNED 10/26/80					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/29/80			23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery			23d. LOCATION CITY OR TOWN Salisbury			23e. COUNTY Wicomico			STATE Maryland	
24. FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME, Salisbury, Maryland		25a. DATE REC'D. BY REGISTRAR OCT 29 1980								25b. REGISTRAR'S SIGNATURE <i>Ernest Lee Hearn</i>					
BP_____															



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 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examining must be notified in advance.

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO. 3027060

1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR										2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			7a. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
LOUIS			A.			Hickman, SR.						59		YRS.		MONTHS DAYS HOURS MIN.	
3. SEX			4. RACE			5. DATE OF BIRTH						6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male			White			MONTH July			DAY 25, 1921			59		YRS.		3 40 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			NEVER MARRIED			<input checked="" type="checkbox"/>		<input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland			U.S.A.			WIDOWED			DIVORCED			<input type="checkbox"/>		<input type="checkbox"/>		WICOMICO	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
SALISBURY			PENINSULA GENERAL HOSPITAL			Cook			Food								
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13b. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
Maryland			Somerset			Crisfield			YES <input checked="" type="checkbox"/>			NO <input type="checkbox"/>			131 Richardson Avenue		
14. FATHER'S NAME			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME			MIDDLE			LAST		
FIRST John			Wilbur			Hickman, Jr.			FIRST Elsie			MIDDLE			Clark		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			16c. INFORMANT			16d. ADDRESS			16e. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Yes			W. W. II			215-16-8192			Louis A. Hickman, Jr.			Minden Avenue			Crisfield, Md. 21811		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																	
PART I. DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) Hepato-renal failure																	
5712 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Alcoholic cirrhosis; alcoholic hepatitis</i> years																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
YES <input type="checkbox"/> NO <input type="checkbox"/>						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>John A. Routenberg M.D.</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10/26/80								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J. A. Routenberg, M.D.</i>			22e. ADDRESS Suite 31, Medical Center; Salisbury, Md.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/28/80			23c. NAME OF CEMETERY OR CREMATORIAL American Legion Cemetery			23d. LOCATION CITY OR TOWN Crisfield			COUNTY Somerset			STATE Md.		
24. FUNERAL DIRECTOR NAME Bradshaw & Sons			ADDRESS Crisfield, Md. 21817			25a. DATE REC'D. BY REGISTRAR OCT 29 1980											

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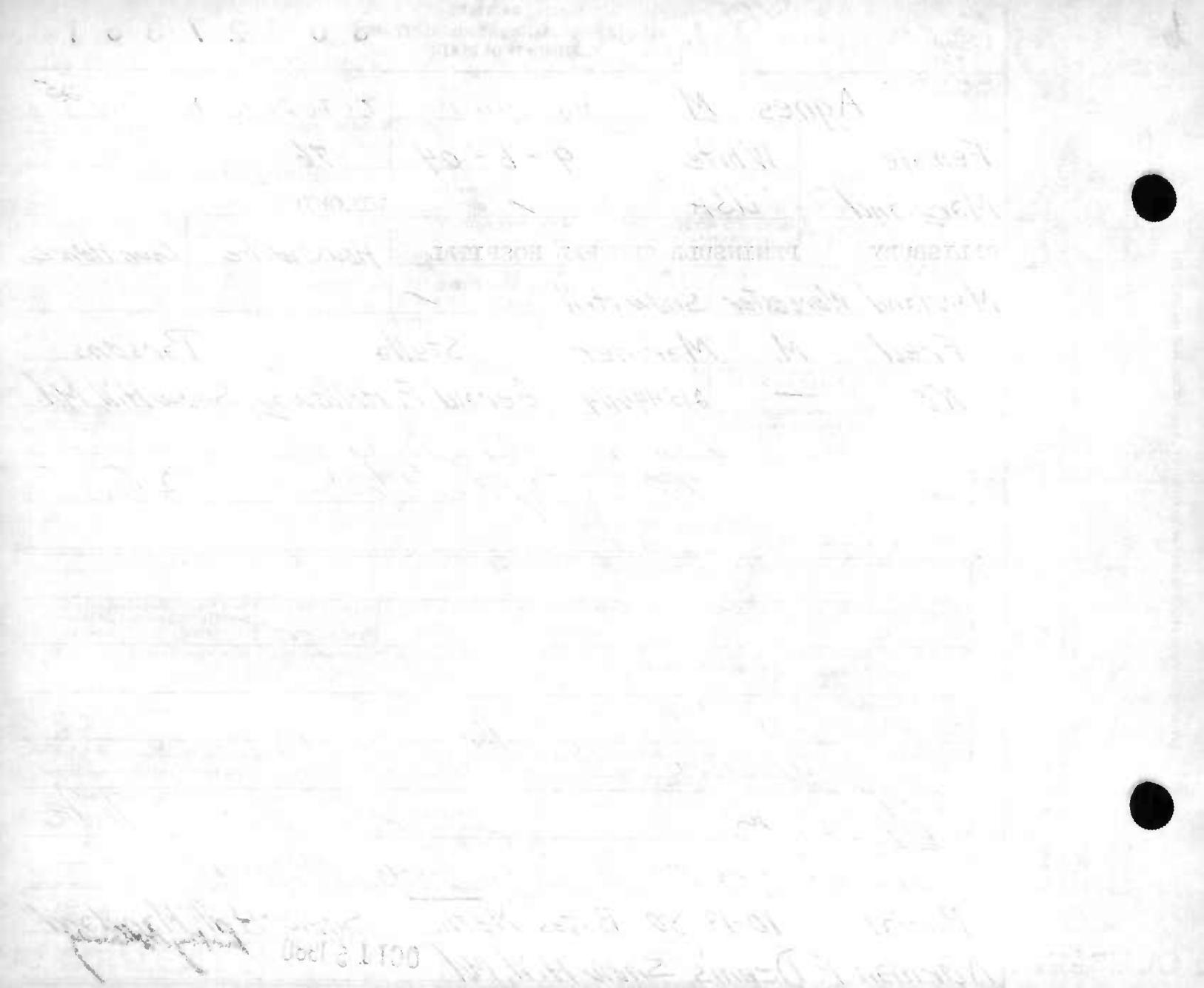
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8027061							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
<u>Agnes M.</u>									<u>HALLOWAY</u>			<u>OCTOBER 10 1980</u>					<u>2:30 P.M.</u>		
3. SEX <u>Female</u>			4. RACE <u>White</u>			5. DATE OF BIRTH MONTH <u>9</u> - DAY <u>6</u> - YEAR <u>04</u>			6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>			7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <u>WICOMICO</u>		10. CITY OR TOWN OF DEATH <u>SALISBURY</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>PENINSULA GENERAL HOSPITAL</u>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
13a. STATE <u>Maryland</u>			13b. COUNTY <u>Worcester</u>			13c. CITY OR TOWN <u>Snow Hill</u>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS								
14. FATHER'S NAME FIRST <u>Fred</u>			MIDDLE <u>M</u>			LAST <u>Mariner</u>			15. MOTHER'S MAIDEN NAME FIRST <u>Stella</u>		MIDDLE			LAST <u>Parsons</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>			16b. SOCIAL SECURITY NO <u>215446114</u>			17. INFORMANT <u>Gerald F. Halloway, Snow Hill Md.</u>			ADDRESS <u>108 Maryland 1 Highway</u>				APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH <u>1 week</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>5334</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												DUE TO, OR AS A CONSEQUENCE OF (b) <u>Stroke by S.C. Ecker</u>							
												DUE TO, OR AS A CONSEQUENCE OF (c) <u>Stroke by S.C. Ecker</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>108 100</u>			21f. LOCATION STREET <u>108 100</u>			CITY OR TOWN <u>Snow Hill</u>		COUNTY <u>Worcester</u>		STATE <u>Maryland</u>						
22a. I certify that (I) this hospital attended the deceased from <u>10/10/80</u> to <u>10/10/80</u> , that (I) (we) last saw the deceased alive on <u>10/10/80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>10/10/80</u>										
22d. PRACTICING STATE (TYPE OR PRINT)			22e. ADDRESS																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>10-13-80</u>			23c. NAME OF CEMETERY OR CREMATORIUM <u>Bates Meth</u>			23d. LOCATION CITY OR TOWN <u>Snow Hill</u>			COUNTY <u>Worcester</u>		STATE <u>Maryland</u>					
24. FUNERAL DIRECTOR NAME <u>Norman F. Dennis</u>			ADDRESS <u>Snow Hill Md</u>			25. DATE REC'D. BY STATE PARTNERSHIP <u>OCT 15 1980</u>													

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 80 27062			
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
			Eva Belle Holloway						10 20 80			845 PM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR					
Female		White		July 8, 1903			77			MONTHS DAYS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Maryland		USA					Wicomico								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (TYPE OF INSTITUTION, CITY, STATE)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Salisbury		Peninsula General Hospital		Operator			Grocery Store								
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13b. STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Mt. Hermon Road					
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME LAST			16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS					
Eugene				Cora						Mr. Edgar L. Holloway (husband)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. (IF YES, GIVE WAR OR DATES)		16c. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			same as 13					
NO															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any												2 days			
DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction												5 days			
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (he) (she) attended the deceased from 10-19, 1980, to 10-20, 1980, the (we) lost sow the deceased alive on 10-20, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.															
22b. SIGNATURE Roger C. Merrill, M.D.												DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22c. DATE SIGNED 10-20-80															
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS Salisbury, Maryland												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 10/23/80			23c. NAME OF CEMETERY OR CREMATORIAL Wicomico Mem. Park			23d. LOCATION CITY OR TOWN Salisbury, Wic. Maryland						
Burial															
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME			ADDRESS Salisbury, MD.			25a. DATE REC'D. BY REGISTRAR 06/24/1980			25b. REGISTRAR'S SIGNATURE Larry Melandy						

Brücke, eine neue Dimension

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										0 27063					
										REG. NO.					
1. FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE ALLEN T.			LAST HOWARD			2a. DATE OF DEATH MONTH OCTOBER 24, 1980		2b. HOUR 8 A.M.	
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH July			DAY 7			6. AGE (IN YEARS LAST BIRTHDAY) YEAR 68		IF UNDER 1 YEAR MONTHS YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED WIDOWED			NEVER MARRIED DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO		MD.	
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL NURSING HOME OR OTHER INSTITUTION Peninsula General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic			12b. KIND OF BUSINESS OR INDUSTRY Automobile						
13a. STATE Maryland			13b. COUNTY Somerset			13c. CITY OR TOWN Crisfield			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 19 Cove St.			
14. FATHER'S NAME FIRST Elton			LAST Howard			15. MOTHER'S MAIDEN NAME FIRST Gertrude			MIDDLE LAST Sterling						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W. W. II			17. INFORMANT Gertrude H. Howard			ADDRESS Same as 13 a, b, c, d, e			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 days			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140			DUE TO, OR AS A CONSEQUENCE OF (b)			DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 10-8, 1980, to 10-24, 1980, that (I) (we) lost sow the deceased alive on 10-24, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Wilber R. Ellis Jr. MD			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10-24-80						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILBER R. ELLIS JR. MD			22e. ADDRESS KAY AVE SALISBURY, MD 21801												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/26/80			23c. NAME OF CEMETERY OR CREMATORIAL Sunnyridge Cemetery			23d. LOCATION CITY OR TOWN Crisfield			23e. COUNTY Somerset Md.			
24. FUNERAL DIRECTOR NAME Bradshaw & Sons			ADDRESS Crisfield, Md. 21817			25a. DATE REC'D. BY REGISTRAR OCT 29 1980			25b. REGISTRAR'S SIGNATURE H. Bradshaw						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpoper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

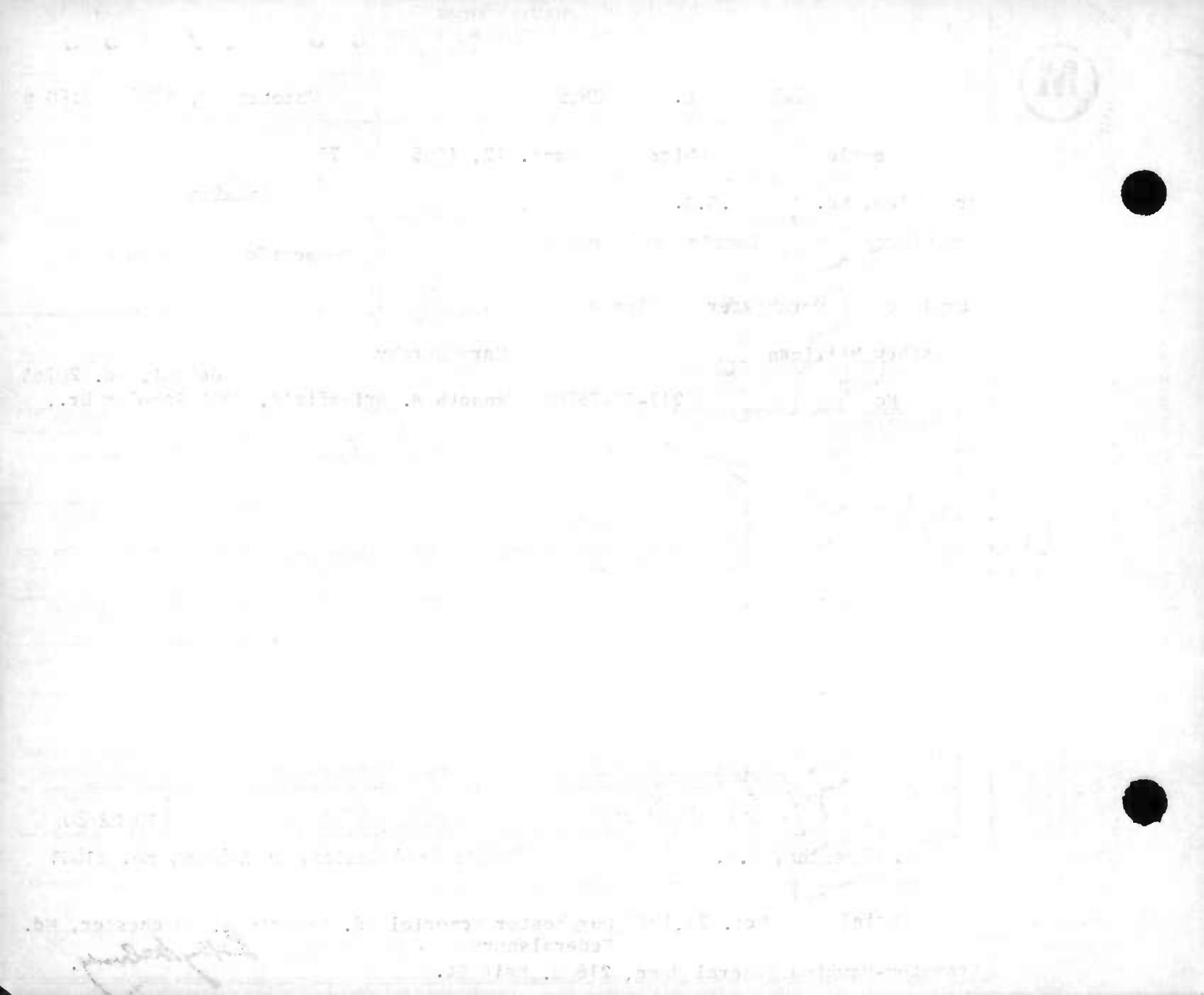
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8027064				
REG. NO.																
1. DECEASED NAME (TYPE OR PRINT)	FIRST			MIDDLE		LAST			20. DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR			
Mamie	F					HULL			October 27, 1980				6:10 AM			
3 SEX <i>Female</i>	4 RACE <i>NEOKD</i>			5. DATE OF BIRTH MONTH <i>17</i>		DAY <i>3</i>			6. AGE (IN YEARS LAST BIRTHDAY) YEAR <i>73</i>				IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS DAYS <i>0</i>	HOURS <i>0</i>	MIN. <i>0</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Wicomico</i>				MD.			
10. CITY OR TOWN OF DEATH <i>Salisbury</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Deer's Head Center</i>											12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Domestic</i>				
13a. STATE <i>MD</i>	13b. COUNTY <i>WI</i>		13c. CITY OR TOWN <i>SAHIS</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS <i>414 HEARNE LANE</i>							
14. FATHER'S NAME FIRST <i>Samuel</i>	MIDDLE <i>Leatherbury</i>			LAST			15. MOTHER'S MAIDEN NAME FIRST <i>IDA</i>			MIDDLE LAST <i>GALE</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>	16b. SOCIAL SECURITY NO. <i>220-329-758</i>			17. INFORMANT <i>ANNIE OWENS</i>			ADDRESS <i>SAHIS MD</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4292</i>																
DUE TO, OR AS A CONSEQUENCE OF (b) <i></i>																
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>Edward P. Ritchings, M.D.</i>	DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>			STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <i>10/27/80</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Edward P. Ritchings, M.D.</i>	22e. ADDRESS <i>Deer's Head Center, Salisbury, Md. 21801</i>															
23a. BURIAL/CREMATION, REMOVAL (SPECIFY) <i>Funeral 11-1-80</i>	23b. DATE <i>11-1-80</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>John Wesley</i>			23d. LOCATION CITY OR TOWN <i>Wicomico</i>			COUNTY		STATE <i>MD</i>				
24. FUNERAL DIRECTOR NAME <i>West-Forks</i>	ADDRESS <i>Salisbury</i>			25. DATE REC'D. BY REGISTRAR <i>OCT 31 1980</i>			26. REGISTRAR'S SIGNATURE <i>Victory McCrory</i>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												0 27065											
												REG. NO.											
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST ZYLDA			MIDDLE L.			LAST HURST			2a. DATE OF DEATH October 22, 1980			2b. HOUR 6:50 p.m.					
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH Sept. 12, 1905			DAY			YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 75			IF UNDER 1 YEAR MONTHS YRS			IF UNDER 24 HRS MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Brookview, Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico			10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Deer's Head Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. STATE Maryland			13b. COUNTY Dorchester			13c. CITY OR TOWN Vienna			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			14. FATHER'S NAME FIRST Mathew Milligan			15. MOTHER'S MAIDEN NAME FIRST Mary Murphy					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217-30-7870D			17. INFORMANT Kenneth B. Brinsfield, 8304 Rambler Dr.,			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4349 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			ADDRESS Adelphi, Md. 20783			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4349 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 10/22/80											
22b. SIGNATURE M. Shrestha			22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Shrestha, M.D.			22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct. 25, 1980			23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial Pd.			23d. LOCATION CITY OR TOWN Cambridge, Dorchester, Md.			CITY OR TOWN			COUNTY			STATE					
24. FUNERAL DIRECTOR NAME Frampton-Hawkins Funeral Home, 216 N. Main St.			ADDRESS Federalsburg			STATE REC'D. BY REGISTRAR NOV 6 1980			REGISTRAR'S SIGNATURE F. Shrestha														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

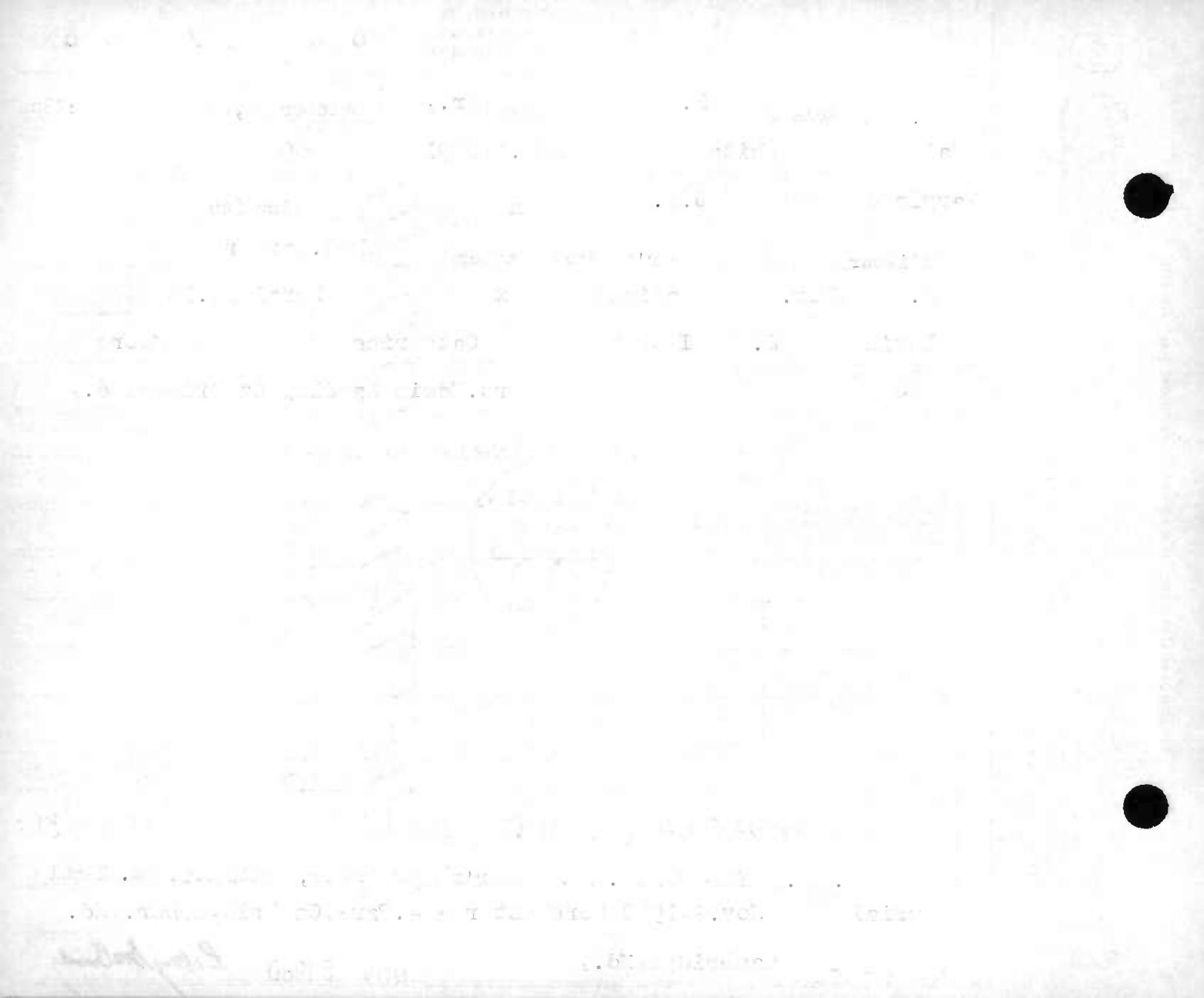
MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

0 27066

1. DECEASED NAME (TYPE OR PRINT)			FIRST B.	MIDDLE Insley	LAST Sr.,	2a. DATE OF DEATH Octover 30, 1980	MONTH DAY YEAR	2b. HOUR 8:23p.m
3. SEX Male		4. RACE White	5. DATE OF BIRTH Feb. 2, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 89	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE SOUTH MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico		
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center		12a. USUAL OCCUPATION Ret. Farmer		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.		13b. COUNTY Dor.	13c. CITY OR TOWN Madison	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Rural Rt. 1t		
14. FATHER'S NAME Levin		MIDDLE J.	LAST Insley	15. MOTHER'S MAIDEN NAME Catherine		16. ADDRESS Moore		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Edwin Handley, Cambridge, Md.,		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. DUE TO, OR AS A CONSEQUENCE OF (b) AS CVD DUE TO, OR AS A CONSEQUENCE OF (c)		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE E. P. RITCHINGS, M.D.		DEGREE M.D.	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/30/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. R. Shewey, Jr.		22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 2, 1980	23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Park, Cambridge, Dor., Md.		23d. LOCATION CITY OR TOWN STREET			
24. FUNERAL DIRECTOR NAME K. R. Shewey, Jr.		25a. DATE REC'D. BY REGISTRAR NOV 5 1980		25b. REC'D. BY TRAR'S SIGNATURE Mrs. Edwin Handley				
ADDRESS Cambridge, Md.,								

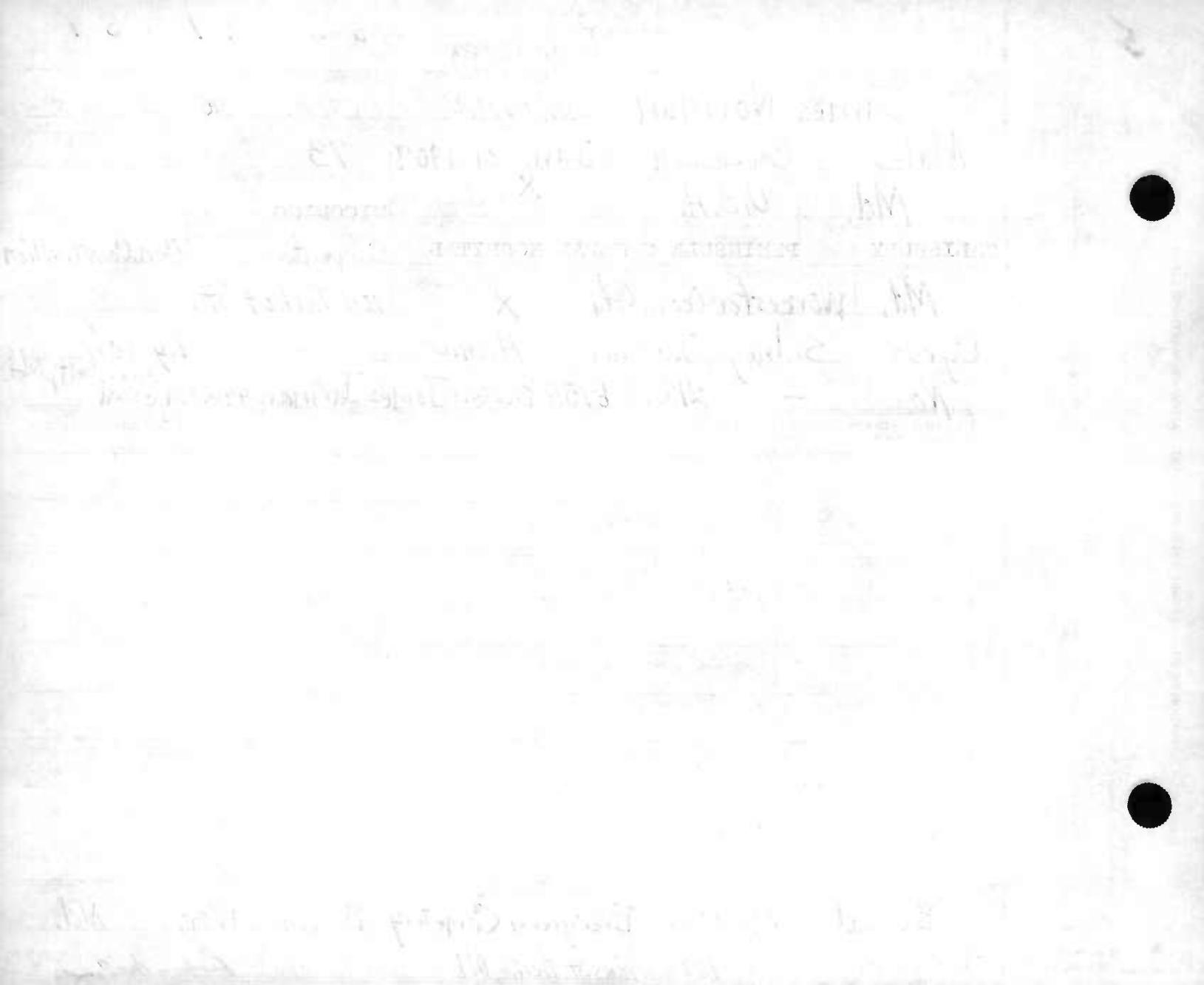


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3027067							
												REG. NO.							
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR							
			James Norman JARMAN						OCTOBER 26 1980			12 08 M							
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN							
Male			Caucasian			Jan. 31 1907			73										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH							
Md.			U.S.A.						WICOMICO			SALISBURY							
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			13. STREET ADDRESS			13a. STATE							
PENINSULA GENERAL HOSPITAL			Carpenter			Gen. Construction			105 Talbot St.			Md.							
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			14. FATHER'S NAME FIRST MIDDLE LAST							
Md.			Worcester Ocean City						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			Cyrus Sidney Jarmen Anna Lynch							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			16c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs.							
No			212-18-6455			Burton James Jarmen 442 Ridge Road													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b)			DUE TO, OR AS A CONSEQUENCE OF (c)													
4409																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
9/9			Emphysema																
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from 10/24 1980 to 10/26 1980, the (2) (we) last saw the deceased alive on 10/26 1980 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (we) did not view the body after death.																			
22b. SIGNATURE C. R. Layton Jr.			22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22e. DATE SIGNED 10-26-80										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/29/80			23c. NAME OF CEMETERY OR CREMATORIAL Evergreen Cemetery			23d. LOCATION CITY OR TOWN Berlin			COUNTY STATE Wor. Md.							
24. FUNERAL DIRECTOR NAME Anna A. Burbar			ADDRESS 108 Williams St. Berlin, Md.			25a. DATE REC'D. BY REGISTRAR OCT 31 1980			25b. REGISTRAR'S SIGNATURE Layton Jr.										

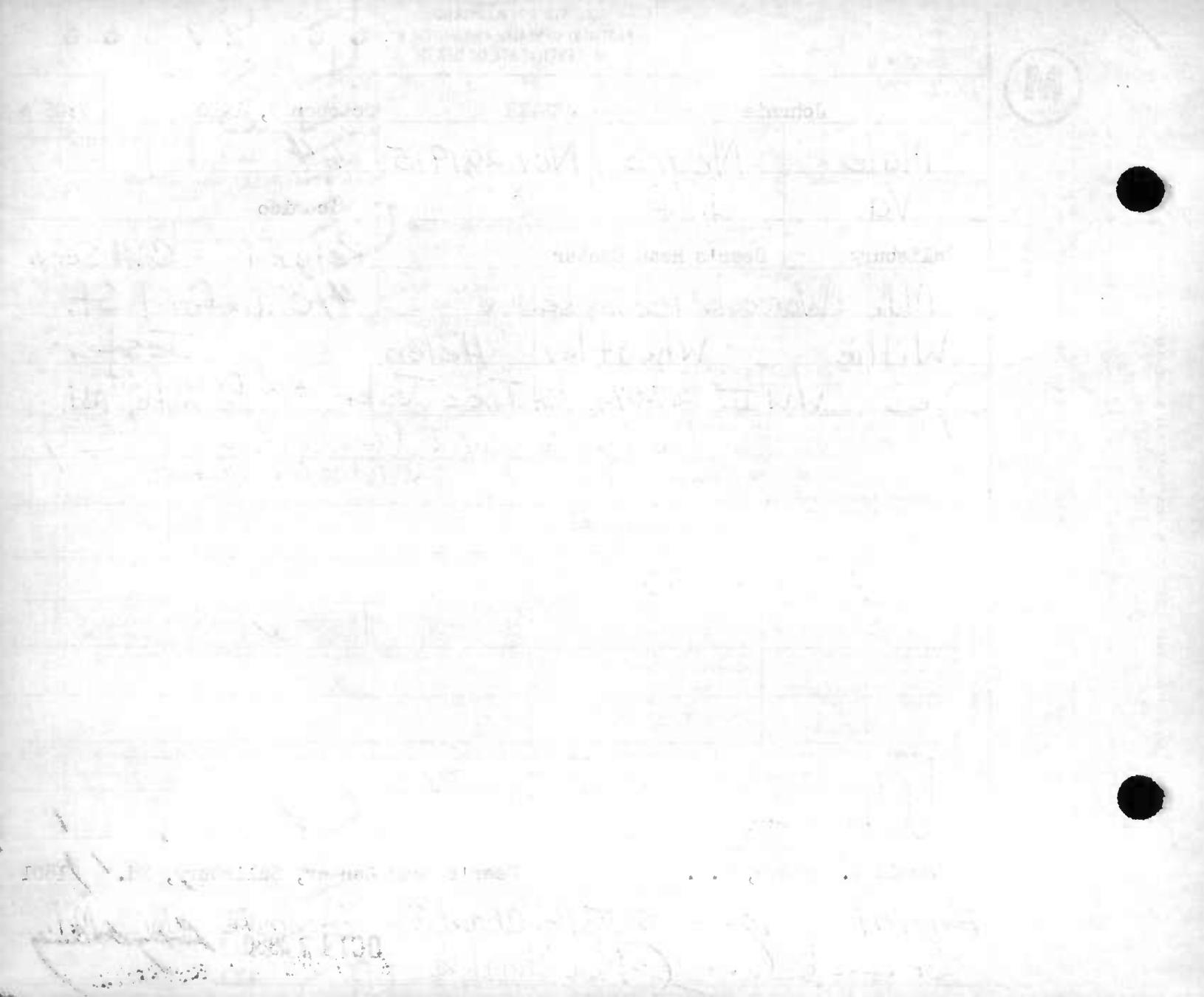


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3 0 2 7 0 6 8			
1 - FOR STATE REGISTRAR				REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH				MONTH	DAY	YEAR	2b. HOUR			
Johnnie				JESTER	October 9, 1980							7:05 p			
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR Nov. 20, 1915		6. AGE (IN YEARS, LAST BIRTHDAY) 64				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico				MD.					
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired				12b. KIND OF BUSINESS OR INDUSTRY Civil Serv.					
13a. STATE Md.		13b. COUNTY Worcester		13c. CITY OR TOWN Pocomoke		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 410 Oxford St.							
14. FATHER'S NAME Willie		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Helen		16. SOCIAL SECURITY NO. 217-07-1370A		17. INFORMANT ADDRESS Inez Jester 410 Oxford St. Pocomoke, Md.							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II		16c. APPROXIMATE INTERVAL BETWEEN INJURY AND DEATH 29		16d. IMMEDIATE CAUSE (a) Ca of larynx & laryngectomy & radiation & chemo tx									
16e. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1619		16f. DUE TO, OR AS A CONSEQUENCE OF (b)		16g. DUE TO, OR AS A CONSEQUENCE OF (c)											
16h. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Hernoma															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Leonid V. Maldve, M.D.		22c. DEGREE		22d. ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 1/18/81									
22f. PHYSICIAN'S NAME (TYPE OR PRINT) Leonid V. Maldve, M.D.		22g. ADDRESS Deer's Head Center, Salisbury, Md.													
23a. BURIAL, CREMATION, REMOVAL (CITY) Burial		23b. DATE 10-13-80		23c. NAME OF CEMETERY OR CREMATORIAL Tindley Chapel Cem.		23d. LOCATION CITY OR TOWN Pocomoke		23e. COUNTY Wicomico		STATE Md.					
24. FUNERAL DIRECTOR NAME Doris L. New Church, Va.		25e. DATE OCT 17 1980		25f. REGISTRATION NO. REC'D. FROM STATE TO STATE											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please do not be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached from use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 3027069			
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR October 5, 1980									2b. HOUR 9:35 AM			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST Florence Catherine Kline			5. DATE OF BIRTH MONTH DAY YEAR March 16, 1900			6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
3. SEX Female			4. RACE White			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico			10. HOUR 9:35 AM			
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			11. CITIZEN OF WHAT COUNTRY? USA			12a. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Peninsula General Hospital			12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) operator		12c. KIND OF BUSINESS OR INDUSTRY Clothing Mfg. Co.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland			13b. COUNTY Wicomico			13c. CITY OR TOWN Hebron			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 212 E. Lillian St.		14. FATHER'S NAME Thomas William Gordy	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT Mrs. Lynette K. Kenney			18. ADDRESS Rt. 1, Box 160C Hebron, Md.			15. MOTHER'S MAIDEN NAME Alberta Florence Howard			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Gardia Decompensata</i>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriole Cerebral</i> Disease.															
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic obstructive pulmonary disease</i>															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Chronic obstructive pulmonary disease</i>															
19a. MEDICAL CERTIFICATION DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (we) attended the deceased from 10-5-1980 to 10-5-1980, that (I) (we) last saw the deceased alive on 10-5-1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>James L. Clifford</i>			22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 10-5-80						
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>James L. Clifford</i>			22f. ADDRESS #12 MEDICAL CENTER, SASSACET, MD.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/9/80			23c. NAME OF CEMETERY OR CREMATORIAL Hebron Cemetery			23d. LOCATION CITY OR TOWN Hebron, Wicomico			23e. COUNTY STATE			
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md.			25a. ADDRESS HOLLOWAY FUNERAL HOME, Salisbury, Md.			25b. DATE REC'D. BY REGISTRAR OCT 7 1980			25c. REGISTRAR'S SIGNATURE <i>Edgar Bradley</i>						

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 3 AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

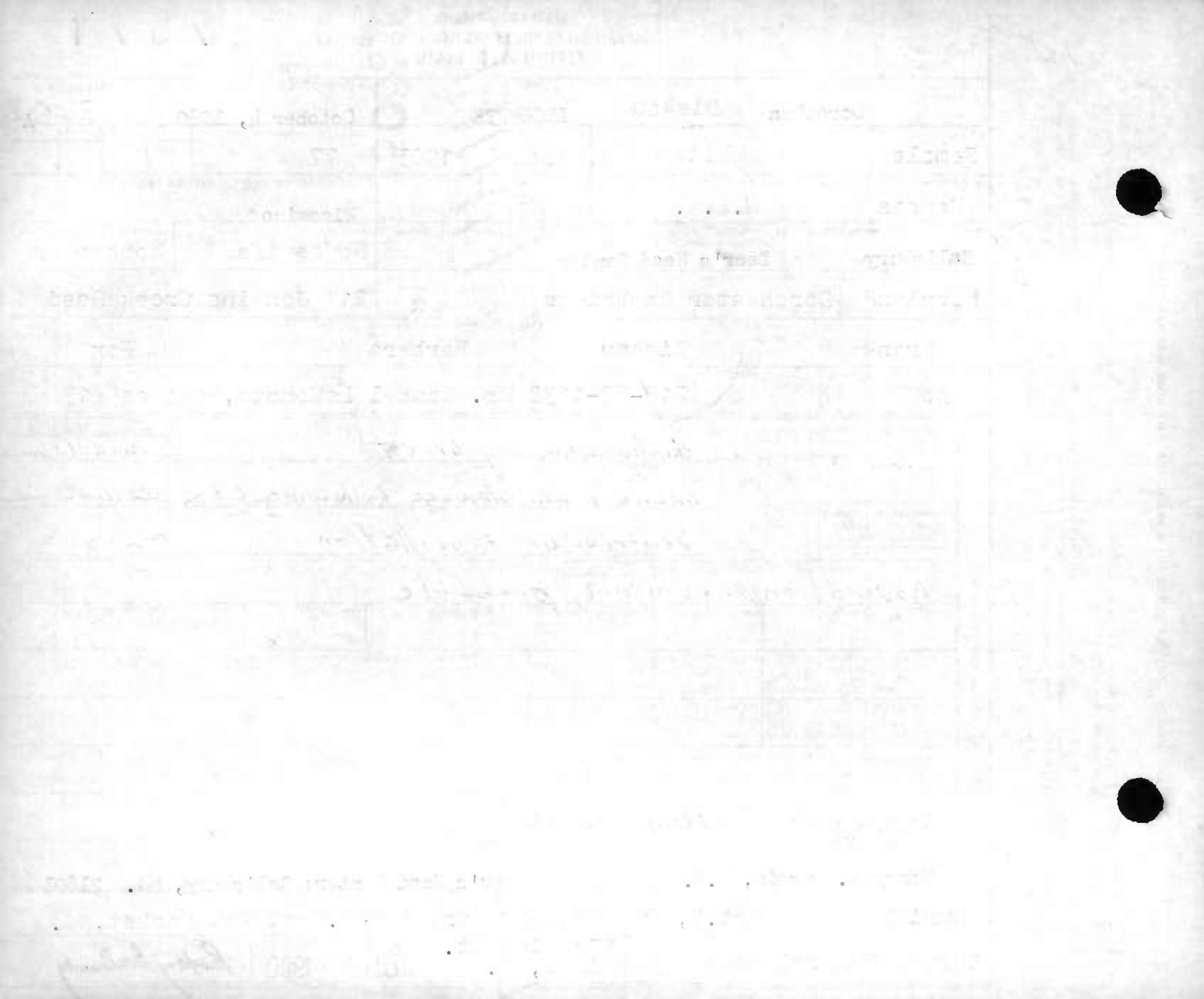
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 27070				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF DEATH ESTI- MATED		2b. MONTH DAY YEAR	2b. HOUR	
LLOYD			M.			LANGFORD						<input checked="" type="checkbox"/> 9-30-80		19	A	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 78 79 yrs.	IF UNDER 1 YR.		IF UNDER 24 HRS.		MONTHS		DAYS		HOURS		MIN		
Male	White	Sep 25, 1902	78 79 yrs.													
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			78. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			NEVER MARRIED DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland			USA									Wicomico				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury			1214 N. Division St.									Factory Worker			Cannin Indus	
13. STATE Md.			13. COUNTY Talbot			13c. CITY OR TOWN Easton			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 307 Elizabeth St.					
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST		LAST					
Anthony						Langford			Annie		Collision					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			219 Tred Avon Avenue				
No			216-16-7306			James Langford			Easton, MD 21601							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion																
410- Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.																
DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Cardiovascular Disease																
DUE TO, OR AS A CONSEQUENCE OF (c)																
APPROXIMATE INTERVAL BETWEN ONSET AND DEATH sudden																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?				
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE <i>Earl L. Royer</i> M.D.																
TITLE (SPECIFY) Deputy MEDICAL EXAMINER																
DATE SIGNED 9-30-80																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN							
Burial			10-3-80			St. Paul's Cemetery			Vienna							
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Zeller Funeral Home, East New Market, Md.						OCT 5 1980										
DHMH - 17 (VR A15 ME (5)) 15M 7/76																

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												0 27071			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Dorothea			Diskau				LECOMPT		October 1, 1980					3:00 AM	
3. SEX Female			4. RACE White				5. DATE OF BIRTH MONTH DAY YEAR March 3 1903		6. AGE (IN YEARS LAST BIRTHDAY) 77		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas			7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico						
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Homemaker						
13a. STATE Maryland			13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 211 Jenkins Creek Road						
14. FATHER'S NAME FIRST Frank			MIDDLE		LAST Diskau		15. MOTHER'S MAIDEN NAME FIRST Barbara		MIDDLE		LAST FOX				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. no		16c. WAR OR DATES		17. INFORMANT 218-58-1138 Mr. Samuel LeCompte, same as #13		ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>cardio-pulmonary arrest</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4279 minutes															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>anoxic brain damage following CPR</u> 22 mos.															
DUE TO, OR AS A CONSEQUENCE OF (c) <u>ventricular fibrillation</u> 22 mos.															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) aspiration pneumonia, probable															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Nancy W. Tustin, M.D.			22c. DEGREE				22d. ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		22e. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nancy W. Tustin, M.D.			22e. ADDRESS Deer's Head Center; Salisbury, Md. 21801												
23a. BURIAL, CREMATION, REMOVAL SPECIES Burial			23b. DATE Oct. 7, 80		23c. NAME OF CEMETERY OR CREMATORIAL CITY OR TOWN East New Market Cem. East New Market, Md.		23d. LOCATION CITY OR TOWN East New Market, Md.		23e. DATE REC'D. BY REGISTRAR OCT 6 1980		23f. REGISTRAR'S SIGNATURE Riley McAleney		COUNTY STATE		
24. FUNERAL DIRECTOR Curran Funeral Home			ADDRESS 308 High St. Cambridge, Md.												



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA. 3. RETAIN PAGE 5, HOW YOU FARE TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1, AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH27072
REG. NO.

1- STATE REGISTRAR		I. DECEASED NAME FIRST MIDDLE LAST						2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR		2b. HOUR	
		ALDEN AYRES LOTSPEICH						OF ESTI- DEATH MATED <input type="checkbox"/> 10-7-80 10:40P			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR.	IF UNDER 24 HRS.	MONTHS	2c. DATE PRONOUNCED DEAD	MONTH DAY YEAR	2d. HOUR		
Male	White	10 2 1892	88				10-7-80 19		11 M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico					
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Merchandise			
13a. STATE Md.		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 815-C Smith St.			
14. FATHER'S NAME FIRST Jacob		MIDDLE Bascom		LAST Lotspeich		15. MOTHER'S MAIDEN NAME FIRST Martha		LAST Ayres			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW. W. I		16c. INFORMANT Angela Lotspeich		17. ADDRESS San Francisco, Calif.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD 4292 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
23a. EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.										TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER	
ADDRESS 409 Camden Ave., Salisbury, Md.										DATE SIGNED 10-9-80	
23b. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23c. DATE		23d. NAME OF CEMETERY OR CREMATORIAL Parksley Cemetery		23e. LOCATION CITY OR TOWN Parksley		COUNTY Accomack Va.			
24. FUNERAL DIRECTOR John J. Williams Williams Funeral Home, Parksley, Va.				25a. DATE REC'D. BY REGISTRAR OR REGISTRAR'S SIGNATURE OCT 22 1980							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

0 27073

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
James Mack				October 25, 1980				4:50 p.m.	
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Male	Negro	Month	Day	Year	MONTHS	DAYS	IF UNDER 24 HRS		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH	
Md.	U.S.A.							Wicomico	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	Deer's Head Center				Laborer				Mill Work
13a. STATE	13b. CO. JNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS		
Md.	Worcester	Stockton	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	R.F.D. 1 Box 109				
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST				MIDDLE	LAST	
Unk.			Grace					?	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.		17. INFORMANT				18. ADDRESS		
No	—		Irene Robinson				417 Dayton St. Show Hill, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Esophageal co. of lung & metastases</u>									
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any: (b) _____ (c) _____									
DOUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET				CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19_____, to 19_____, that (I) (we) last saw the deceased alive on 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE	DEGREE				22c. DATE SIGNED				
E. P. RITCHINGS, M.D.				ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				10/25/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS								
Deer's Head Center, Salisbury, Md. 21801									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL STATION				23d. LOCATION CITY OR TOWN	COUNTY	STATE	
Burial	10-30-80	Mt. Hope Cem.				Stockton	Wor.	Md.	
24. FUNERAL DIRECTOR NAME	ADDRESS				25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE			
Danah Saylor	New Church, Va.				OCT 28 1980	D. RITCHINGS			

0001 88 100

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE WORD "PENDING" IN PENCIL IN ITEM 18. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 27074				
1. FOR STATE REGISTRAR			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10-9-80 11 19 35A M													
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2b. HOUR				
THOMAS			E.			MATTHEWS						11:35A M				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS.			7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10-9-80 19 M		
Male		AA		9 24 31			49									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico									
Virginia		U.S.A.														
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Factory work			12b. KIND OF BUSINESS OR INDUSTRY Seafood		
13a. STATE Va.		13b. COUNTY Accomack		13c. CITY OR TOWN Bloxom			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Post Office							
14. FATHER'S NAME Willie Matthews		FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME Maggie Finney											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 227-34-2921			17. INFORMANT Dorothy Matthews											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 410- Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																
22b. TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER												DATE SIGNED 10-10-80				
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.												ADDRESS 409 Camden Ave., Salisbury, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10-12-80			23c. NAME OF CEMETERY OR CREMATORIAL Macedonia Bapt. Cem.			23d. LOCATION CITY OR TOWN Bloxom-Accomack-Virginia			COUNTY STATE				
24. FUNERAL DIRECTOR NAME Keith G. Wharton Wharton Funeral Home, Accomac, Va.												25a. DATE REC'D. BY REGISTRAR OCT 17 1980				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 30 27075
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR
Edward Joseph Mayer			October 15, 1980		M
3 SEX Male	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 1, 1901	6 AGE (IN YEARS LAST BIRTHDAY) 79	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE COUNTRY Wisconsin	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH WICOMICO	MD.	
10 CITY OR TOWN OF DEATH Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner - Rendering Plant	12b. KIND OF BUSINESS OR INDUSTRY		
13 STATE Maryland	13a. COUNTY Wicomico	13c. CITY OR TOWN Salisbury	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 433 Somerset Ave.	
14. FATHER'S NAME FIRST William	MIDDLE Mayer	15. MOTHER'S MAIDEN NAME FIRST Elizabeth	MIDDLE LAST Joanisse		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 374-05-4987	17. INFORMANT (daughter) Mrs. June Ewing, Dearborn, Mich.	ADDRESS 1649 Sherwood Ct.	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> 4029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any (b) <i>Hypertension and Arteriosclerosis</i> 25 yrs (c) <i>Cardiovascular Disease</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Transitional cell carcinoma of Bladder</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) this physician attended the deceased from <i>Oct 1, 1960</i> to <i>Oct 15, 1980</i> , that (I) (we) last saw the deceased alive on <i>Oct 1, 1980</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Thomas C. Hill Jr., M.D.</i>	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 10/16/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas C. Hill, Jr., M.D.	22e. ADDRESS Salisbury, Maryland				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/17/80	23c. NAME OF CEMETERY OR CREMATORIAL Wicomico Mem. Park	23d. LOCATION CITY OR TOWN Salisbury, WIC., Maryland		
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md.	25. DATE REC'D. BY REGISTRAR OCT 17 1980	25. REGISTRAR'S SIGNATURE <i>Henry McReady</i>			
DHMH - 16 50M 1/76 (VR A 15 (4))					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	0	2	7	0	7	6
										REG. NO.						
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
			Idella Elizabeth McCormick						10 10 80			9 45 AM				
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR				
Female			White			Jan. 28, 1899			81			MONTHS DAYS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS				
Pennsylvania			USA						Wicomico			MONTHS HOURS MIN.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Salisbury			Peninsula General Hospital			Housewife			none							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Maryland			Pr. Geo.			Laurel			Charles S. Jobbins			Margaret Galloway				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			ADDRESS				
No			221-50-4074			Betty R. Allenback			Cardiopulmonary Arrest			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
4292			DUE TO, OR AS A CONSEQUENCE OF (b)			Cardiac Arrest						ATMOS				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.			DUE TO, OR AS A CONSEQUENCE OF (c)			Atmospheric Cardiovascular Arrest Yrs						HRS				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from 10/11/80 19 to 10/10 19 80, that (I) (we) lost saw the deceased alive on 10/10 19 80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) (did not) view the body after death.																
22b. SIGNATURE Donald M. Wood, M.D.			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10/10/80							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS													
Donald M. Wood, M.D.			Salisbury, Maryland													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/13/80			23c. NAME OF CEMETERY OR CREMATORIAL Gracelawn Mem. Park			23d. LOCATION Wilmington, County Delaware New Castle							
24 FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME, Salisbury, Md.			ADDRESS			25a. DATE REC'D. BY REGISTRAR OCT 14 1980			25b. REGISTRAR'S SIGNATURE Lester Holloway							
0201 DHMH-16 30M 2/80 (VRA 15.4)																

1970-1971 Budget

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 must be filled in before page 1.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												30 : 27077	
												REG. NO.	
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR 7 45 P.M.	
Martha Joanne Meilhammer									October 9, 1980				
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
Female		White		Nov. 13, 1898			81 YRS.						
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH WICOMTCO MD.						
East Germany		USA											
10 CITY OR TOWN OF DEATH SALISBURY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY					
		PENINSULA GENERAL HOSPITAL			Housewife			none					
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13b STATE Maryland		13b COUNTY Wicomico		13c. CITY OR TOWN Salisbury			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS Naylor Mill Road			
14. FATHER'S NAME FIRST MIDDLE LAST Bruno Market					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (unknown)								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO		17 INFORMANT (son)			ADDRESS			18b APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No		220-28-4623D		Mr. Carl Meilhammer, Salisbury, Md.									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)													
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF													
Acute Myocardial Infarction													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Hypertension - Hypothyroidism													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN					
22a I certify that (I) (this hospital) attended the deceased from saw the deceased alive on above, (I) (we) (did) (did not) witness the body after death.		22b DEGREE						COUNTY			STATE		
22c. SIGNATURE											22c. DATE SIGNED 10/9/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS											
O. J. Burton, M.D.		Salisbury, Md.											
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/13/80		23c. NAME OF CEMETERY OR CREMATORIAL Springhill Mem. Gardens			23d. LOCATION CITY OR TOWN Salisbury, Wic., Maryland			COUNTY		STATE	
24 FUNERAL DIRECTOR NAME John R. Mercer		ADDRESS P.O.B. 1802 Snow Hill		25a. DATE REC'D. BY REGISTRAR OCT 14 1980			25b. REGISTRAR'S SIGNATURE Peter H. Hickey						

BP _____

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and the following

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner/must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8027079								
												REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	26 HOUR								
Harry R.					Morrill	October			6	1980		4:50 AM								
3. SEX			1. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR										
Male.			Caucasian	MONTH	DAY	YEAR	70	IF UNDER 24 HRS			MONTHS	DAYS	HOURS	MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.								
Gai			U.S.A.						Wicomico											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Salisbury			Peninsula General Hospital			Chef			Food Service											
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS											
Md.		Worcester		Ocean City		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			6 N. Division St.											
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. ADDRESS			Birch								
Charles			—		Morrill	Gertrude														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
Yes			W.W. II			261-40-3612			M.R. Carey, Rt 2, Box 297, Berlin, Md.			MWS								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																				
PART I. DEATH WAS CAUSED BY:																				
IMMEDIATE CAUSE (a)												Respiratory Arrest								
4292																				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.																				
DUE TO, OR AS A CONSEQUENCE OF (b)												Cerebrovascular Hemorrhage			YRS					
{																				
DUE TO, OR AS A CONSEQUENCE OF (c)												Atherosclerotic Cardiovascular Disease			428					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
									YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
			P.M. 19																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from												8/14 1980			to			10/6 1980		
saw the deceased alive on												10/6/80 19			and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
above, (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED								
Donald M. Wm, MD												10/6/80								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			Peninsula General Hospital														
D. M. Wm MD																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY STATE								
Burial			10/14/80			Md. Eastern Shore Veterans Cem. Hurlock			Dorchester			Md.								
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
Ann A. Buckley			408 Williams St. Berlin Md.			OCT 20 1980			Randy McElroy											

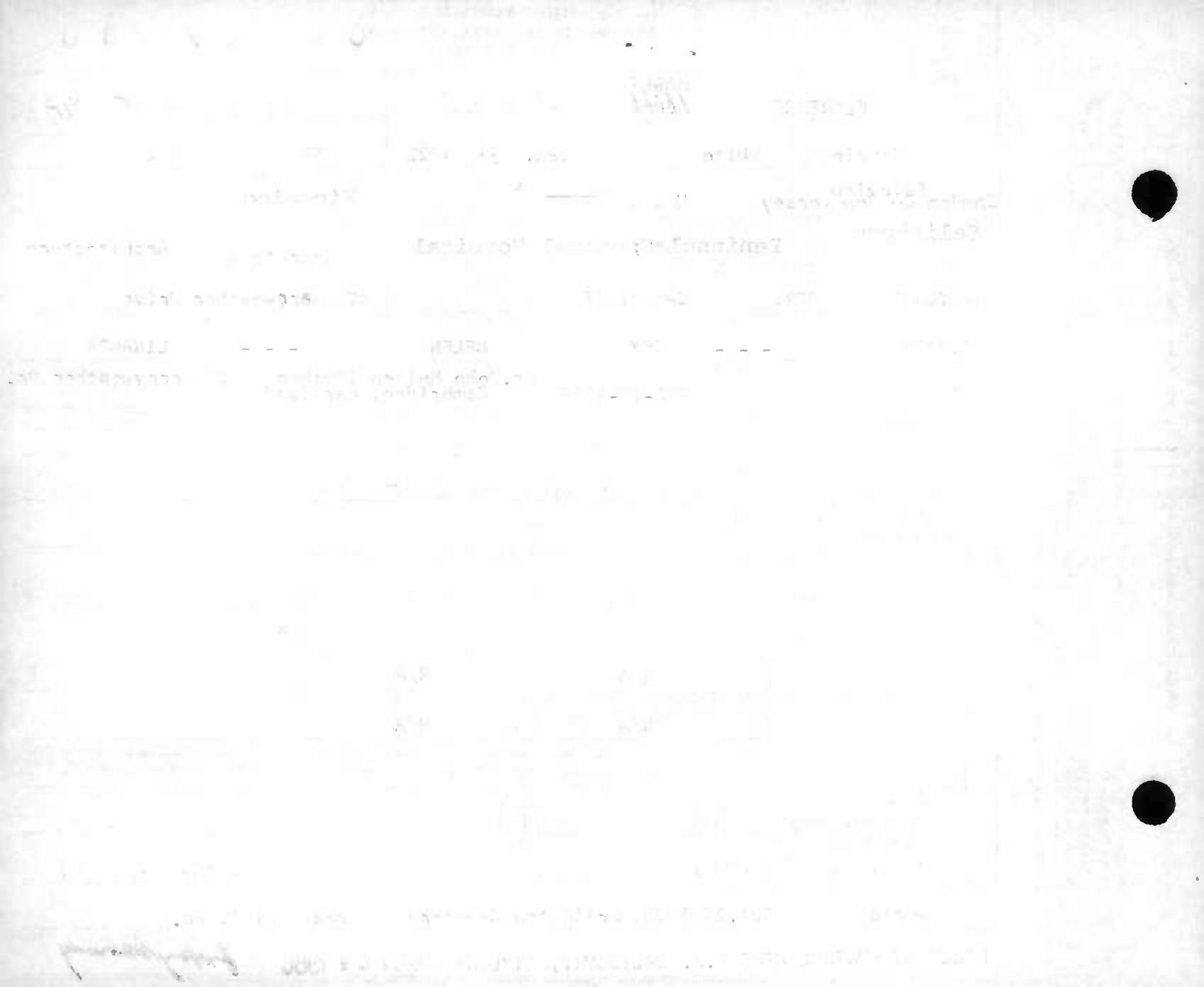
060 05730

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8027080			
										REG. NO.			
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b. HOUR			
I. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST				OCTOBER 21, 1980 9 A.M.		
FLORENCE			MABLE		REBEL		MULLEN						
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH Jan. DAY 31 YEAR 1922			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS 08 DAYS 20	
									58			IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE COUNTRY Camden Co., New Jersey			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico				
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Peninsula General Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary			12b. KIND OF BUSINESS OR INDUSTRY Architecture	
13a. STATE MARYLAND			13b. COUNTY DOR.			13c. CITY OR TOWN CAMBRIDGE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS #28 Merryweather Drive	
14. FATHER'S NAME FIRST ELWOOD			MIDDLE - - -			LAST HOEY			15. MOTHER'S MAIDEN NAME FIRST HELEN			LAST LINAMEN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 182-14-1765			16c. INFORMANT Mr. John Mullen (Husband)			ADDRESS #28 Merryweather Dr. Cambridge, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcis - Respiratory Arrest</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>complications 2^o to Breast Cancer</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) N/A							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A			21f. LOCATION STREET N/A			CITY OR TOWN		COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Joseph R. Grasso			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10-21-80				
22d. ADDRESS 1300 S. DIVISION ST. SALISBURY MD 21801													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct. 25/1980			23c. NAME OF CEMETERY OR CREMATORIAL Arlington Cemetery			23d. LOCATION CITY OR TOWN Drexel Hill, Pa.			23e. COUNTY STATE	
24. FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME P.A. SALISBURY, MARYLAND									25a. DATE REC'D. BY REGISTRAR Oct 24 1980			25b. REGISTRAR'S SIGNATURE Joseph Kennedy	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be mailed to the State Dept. of Health and Mental Hygiene for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate should be filed within 72 hours after death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 27081					
										REG. NO.					
1. FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			7a. DATE OF DEATH		MONTH	DAY	YEAR	7b. HOUR	
			Rebecca E. Munden						October 16, 1980				1980	3:00 AM	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		# UNDER 24 HRS		
Female			NEGRO			9 - 30 - 96			84		YEARS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO						
DRUM			USA						MD.						
10. CITY OR TOWN OF DEATH SALISBURY			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PENINSULA GENERAL HOSPITAL						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
									Domestic		Housewife				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE Norfolk Va.			13b. COUNTY Norfolk			13c. CITY OR TOWN Norfolk			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 522 VIRGINIA AVE				
14. FATHER'S NAME Ahrul A. PERART			15. MOTHER'S MAIDEN NAME Eure								LAST				
											Cross				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
			228-369400			Arthur Cooke			Norfolk, Va. 611 New Jersey Ave						
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										DUE TO, OR AS A CONSEQUENCE OF (b) hypertension					
										DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 15, 1980</u> to <u>Oct. 16, 1980</u> , that (I) (we) last saw the deceased alive on <u>Oct. 15, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Rodney A. Wenrich, M.D.										22c. DATE SIGNED 10/16/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS												
RODNEY A. WENRICH			KAY AVE. SALISBURY MD. 21801												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE		
BURIAL			10-20-80			ROOSEVELT Cemetery			CHESAPEAKE		PRINCESS A. VA				
24. FUNERAL DIRECTOR NAME Jolley Mem. Chapel			ADDRESS 10th Jersey Rd., Salis. Md.			25a. DATE REC'D. BY REGISTRAR OCT 24 1980			25b. REGISTRAR'S SIGNATURE F. Jolley/Brady						

BP_____

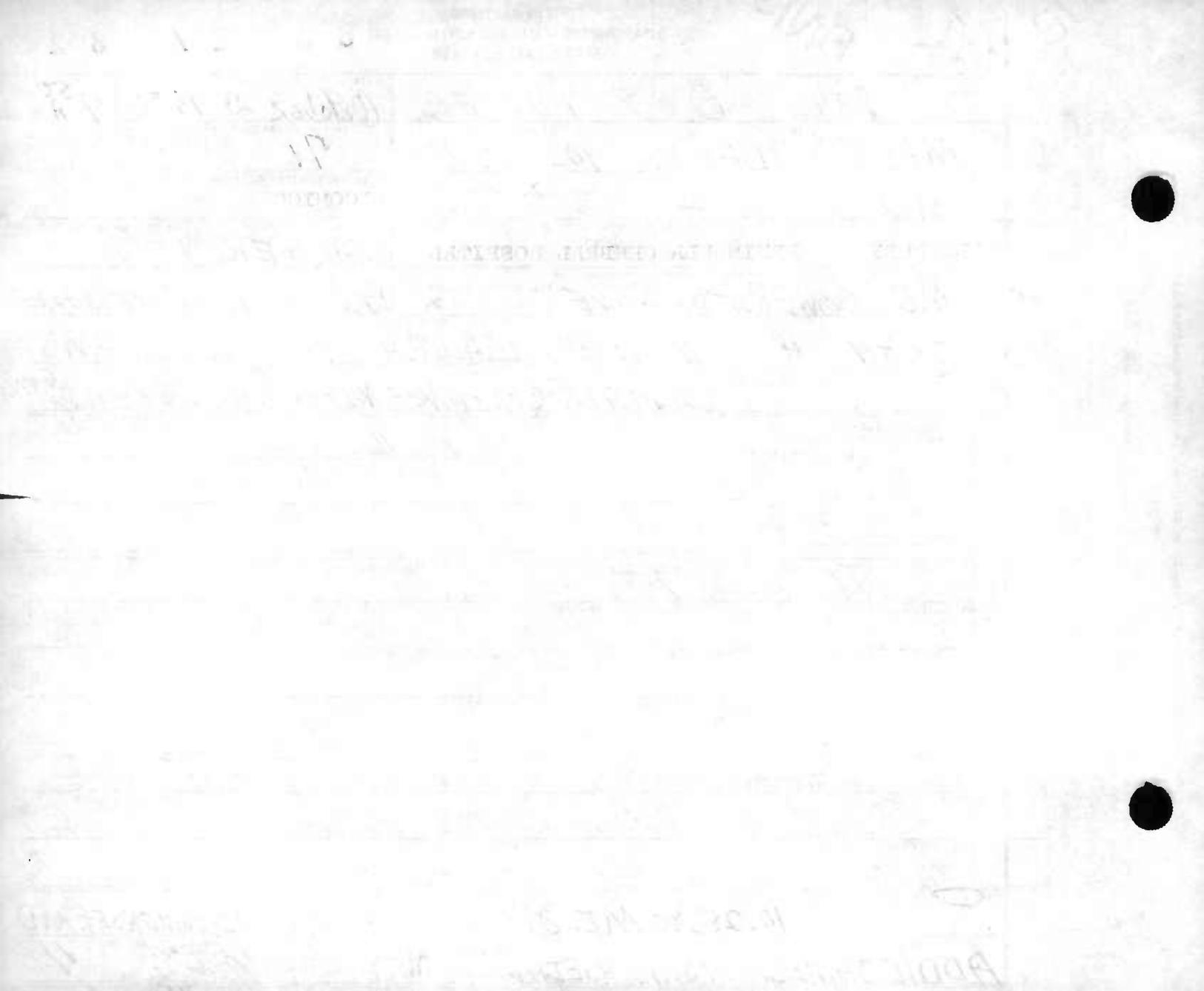
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8027082	REG. NO.			
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			October 21 1980			9:30 AM				
PAUL E. NUTTER																
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. # UNDER 1 YEAR MONTHS DAYS HOURS MIN				
MALE			BLACK			10-15-09			71			YRS				
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO			10. DATE REC'D. BY REGISTRAR				
MD			USA									OCT 31 1980				
10. CITY OR TOWN OF DEATH SALISBURY			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN A HOSPITAL, GIVE STREET ADDRESS) PENINSULA GENERAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER			12b. KIND OF BUSINESS OR INDUSTRY			11. STREET ADDRESS 1828 E. 24TH PRINCESS AVE				
13a. STATE MD			13b. COUNTY SOMERSET			13c. CITY OR TOWN D. ANNE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			14. FATHER'S NAME JOHN H. NUTTER		15. MOTHER'S MAIDEN NAME LAURA F. WILLIAMS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT CONSTANCE NUTTER. PH2-1082-241-10-21-80			18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1602 Carcinoma of Maxillary Sinus with Metastasis			19. ADDRESS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost			b) DUE TO, OR AS A CONSEQUENCE OF			c) DUE TO, OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Old Myocardial Infarction																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from 10/20/80 to 10/21/80, that (I) (we) lost soul the deceased alive on 10/21/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22b. DATE SIGNED 10/21/80				
22b. SIGNATURE Benito S. Chan MD			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BENITO S. CHAN			22e. ADDRESS 547-1 Riverside Drive.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 10-25-80			23c. NAME OF CEMETERY OR CREMATORIAL MT. ZION			23d. LOCATION CITY OR TOWN COUNTY STATE			25a. DATE REC'D. BY REGISTRAR OCT 31 1980		25b. REGISTRAR'S SIGNATURE Lester L. Chan		
24. FUNERAL DIRECTOR ADDIE JAMES, HOT SOMERSET AVE. PA			ADDRESS ANNE													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8027083
											REG. NO.	
1 - STATE REGISTRAR	1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
	FRANK S. Parker						October, 23, 1980				12:01 PM	
3 SEX	4 RACE			5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Male	WHITE			6-12-1897			83 YRS.					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			10 IF UNDER 24 HRS		
DELAWARE	USA						WICOMICO					
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
SALISBURY	PENINSULA GENERAL HOSPITAL						CONCRETE BLOCK MFG.					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
13b. STATE DELAWARE	13c. COUNTY SUSSEX	13f. CITY OR TOWN MILLSBORO						R.D. 2, BOX 320				
14 FATHER'S NAME	MIDDLE	15. MOTHER'S MAIDEN NAME			MIDDLE	16. ADDRESS			LAST			
ALBERT		FANNIE			T.	RUTH BRITTINGHAM, MILLSBORO, DEL.						
18a CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)							Arterio Sclerotic Heart Disease unknown					
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any												
DUE TO, OR AS A CONSEQUENCE OF (b)												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
YES <input type="checkbox"/> NO <input type="checkbox"/>							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9-21, 1980, to 10-23, 1980, that (I) (we) last saw the deceased alive on 10-23, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Wilber R. Ellis Jr. MD		22c. DEGREE Q. Ellis Jr. MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 10-23-80				
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS										
WILBER R. ELLIS JR. MD		KAY AVE. SALISBURY MD 21801										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 10-26-80		23c. NAME OF CEMETERY OR CREMATORIAL MILLSBORO CEMETERY		23d. LOCATION CITY OR TOWN MILLSBORO, SUSSEX, DELAWARE		23e. COUNTY STATE				
BURIAL												
24. FUNERAL DIRECTOR Frank Parker		25a. DATE REC'D. BY REGISTRAR OCT 29 1980			25b. REGISTRAR'S SIGNATURE Larry A. Crissey							
H. Horst Nelson												

1948-1950 AIRPORT

1952-53

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Burial/Transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8027084
				REG. NO.
1. FOR STATE REGISTRAR	FIRST MIDDLE LAST	20. DATE OF DEATH MONTH DAY YEAR	26. HOUR	
I. DECEASED NAME (TYPE OR PRINT)	Helen Louise	POGRABSKI	10:38 AM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 13, 1909	6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Chestertown, Md.	7b. CITIZEN OF WHAT COUNTRY? USA	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico	
10. CITY OR TOWN OF DEATH Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Peninsula General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Cashier	12b. KIND OF BUSINESS OR INDUSTRY Life Insurance	
13a. STATE Maryland	13b. COUNTY Wicomico	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS Rt. 3, Shavox Road, Box 2u8	
14. FATHER'S NAME FIRST Laurence	MIDDLE R.	15. MOTHER'S MAIDEN NAME FIRST Helen	MIDDLE LAST Bramble	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (YES, GIVE WAR OR DATES) 213-22-9300	17. INFORMANT Mr. Anthony S. Pograbski (husband) same as 13	ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Extremis Colon Cancer</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
<p>1539</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</p> <p>DUE TO, OR AS A CONSEQUENCE OF (b)</p> <p>DUE TO, OR AS A CONSEQUENCE OF (c)</p>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b.				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN COUNTY STATE	
22a. I certify that (1) <input type="checkbox"/> (the hospital) attended the deceased from <u>10/14</u> , 19 <u>80</u> , to <u>10/25</u> , 19 <u>80</u> , that (1) <input type="checkbox"/> lost soul the deceased alive on <u>10/24</u> , 19 <u>80</u> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (1) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.				
22b. SIGNATURE <u>Joseph A. Grasso</u>	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 10/25/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Joseph A. Grasso</u>	22e. ADDRESS Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/29/80	23c. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Park	23d. LOCATION CITY OR TOWN Salisbury, Wis., Maryland COUNTY STATE	
24. FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME, Salisbury, Maryland	ADDRESS	25a. DATE REC'D. BY REGISTRAR OCT 30 1980	25b. REGISTRAR'S SIGNATURE <u>Henry H. Bly</u>	

Jackwell (unpublished)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 30 27085			
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) ELWOOD			MIDDLE AUSTIN			LAST Pusey		Oct. 16, 1980		23A M			
3. SEX male		4. RACE White		5. DATE OF BIRTH MONTH Jan. DAY 31 YEAR 1914			6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS 6 DAYS 6		IF UNDER 24 HRS HOURS 23 MIN. 0		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Princess Anne, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico		MD.				
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Security Guard			12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE Maryland				13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 409 Hastings Street			
14. FATHER'S NAME FIRST Curtis			MIDDLE C.		LAST Pusey		15. MOTHER'S MAIDEN NAME FIRST Vera		MIDDLE		LAST Baker		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-01-7280		17. INFORMANT Mrs. Susie I. Pusey (wife)		ADDRESS same as 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC PROSTATIC ADENOCARCINOMA										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 MONTHS			
185- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b) CHRONIC OBSTRUCTIVE PULMONARY DISEASE													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) OCTOBER 15 1980		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (1) (this hospital) attended the deceased from OCTOBER 10 1980 to OCTOBER 16 1980 , that (1) (we) lost saw the deceased alive on OCTOBER 15 1980 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.										22b. DATE SIGNED 10/16/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN H. SHENASKY		22e. ADDRESS 16 MEDICAL CENTER, SALISBURY, MD 21801		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (SPECIES) Burial		23b. DATE 10/18/80		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION CITY OR TOWN Salisbury		23e. COUNTY Wicomico		23f. STATE Md.			
24. FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME		ADDRESS Salisbury, Md.		25a. DATE REC'D. BY REGISTRAR OCT 20 1980		25b. REGISTRAR'S SIGNATURE Larry Melady							
DHMH-16 30M 2/80 (VRA 15, 4)													

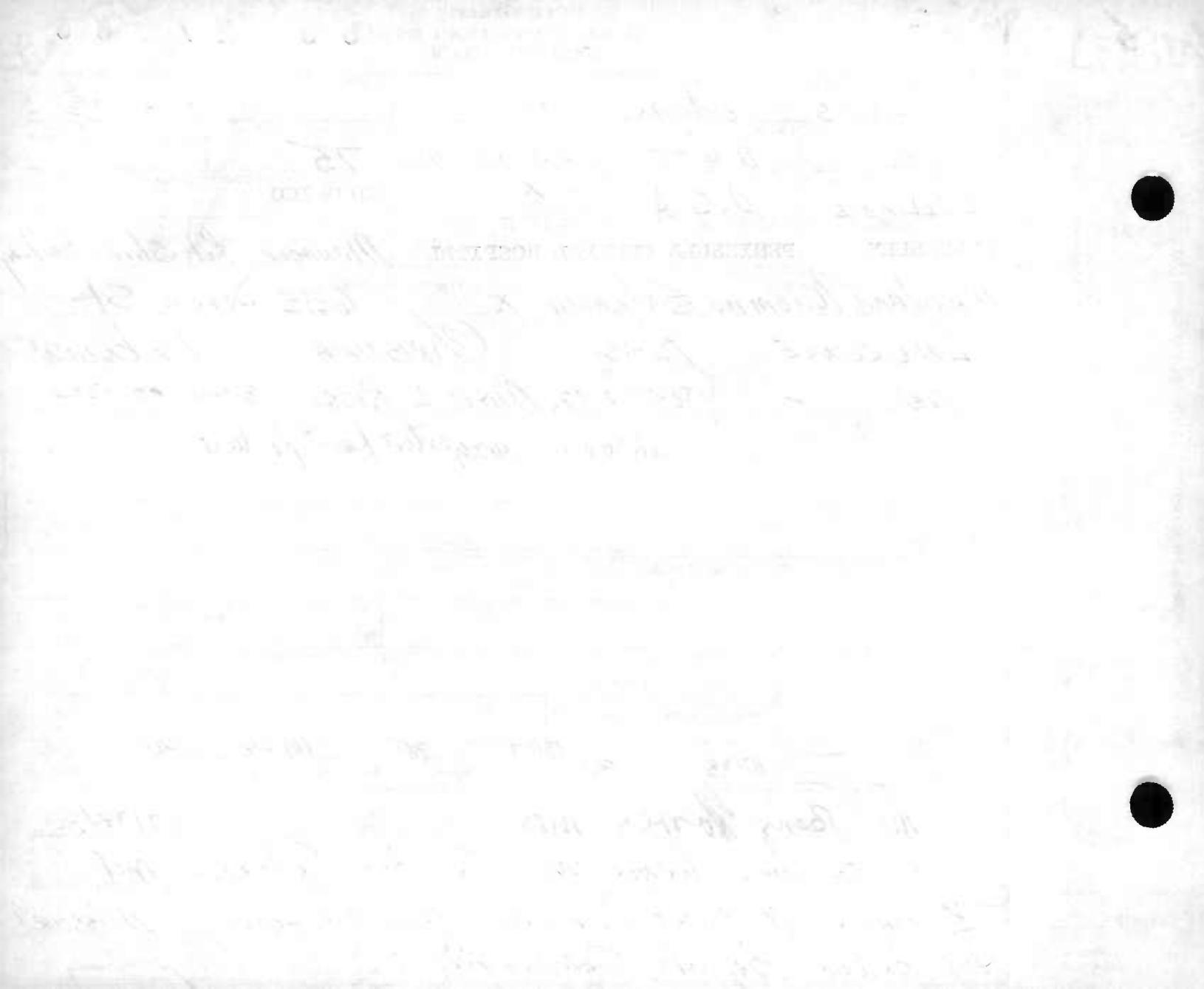
Integerrima *Leucanthemum vulgare*

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8027086					
												REG. NO.					
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR		
			LOUIS EDGAR Rossi						10/28/80			10/25	12/24	M	12b		
3 SEX			4 RACE			5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			# UNDER 1 YEAR		# UNDER 24 HRS			
Male			WHITE			JAN 22, 1905			75			MONTHS	YEARS	MONTHS	YEARS	HOURS	MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH WICOMICO			10c					
10 CITY OR TOWN OF DEATH SALISBURY			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PENINSULA GENERAL HOSPITAL			12a USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING DAY) Manager Ret. Shirt Factory			12b KIND OF BUSINESS OR INDUSTRY			12c					
13a STATE Maryland			13b COUNTY Wicomico			13c CITY OR TOWN Salisbury			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS 633 Dover St.			13f		
14 FATHER'S NAME FIRST MIDDLE LAST			15 MOTHER'S NAME FIRST MIDDLE LAST			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO 180-03-2172			17 INFORMANT Mac L. Rossi			18 ADDRESS 8006 13th		
18b APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
18c CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			18d DUE TO, OR AS A CONSEQUENCE OF (b)			18e DUE TO, OR AS A CONSEQUENCE OF (c)			18f			18g			18h		
18i			18j			18k			18l			18m			18n		
19a MEDICAL CERTIFICATION			19b DATE OF OPERATION			19c CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20c		
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d			21e			21f		
21g			21h			21i			21j			21k			21l		
22a I certify that (I) (the hospital) attended the deceased from 10/17, 1980, to 10/28, 1980, that (I) (we) last saw the deceased alive on 10/28, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b SIGNATURE W. Benjamin Horner, MD			22c DEGREE MD			22d ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN			22e DATE SIGNED 12/28/80			22f		
22g			22h			22i			22j			22k			22l		
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE 10-31-80			23c NAME OF CEMETERY OR CREMATORIAL Oak Grove Cem.			23d LOCATION CITY/TOWN ST. LOUIS			23e COUNTY Missouri			23f STATE		
24 FUNERAL DIRECTOR NAME Hill-Baker-Bounds, Salisbury, Md			24a ADDRESS			24b DATE REC'D. BY REGISTRAR OCT 31 1980			24c REGISTRAR'S SIGNATURE Hilary McCloskey			24d			24e		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be satisfied of one:

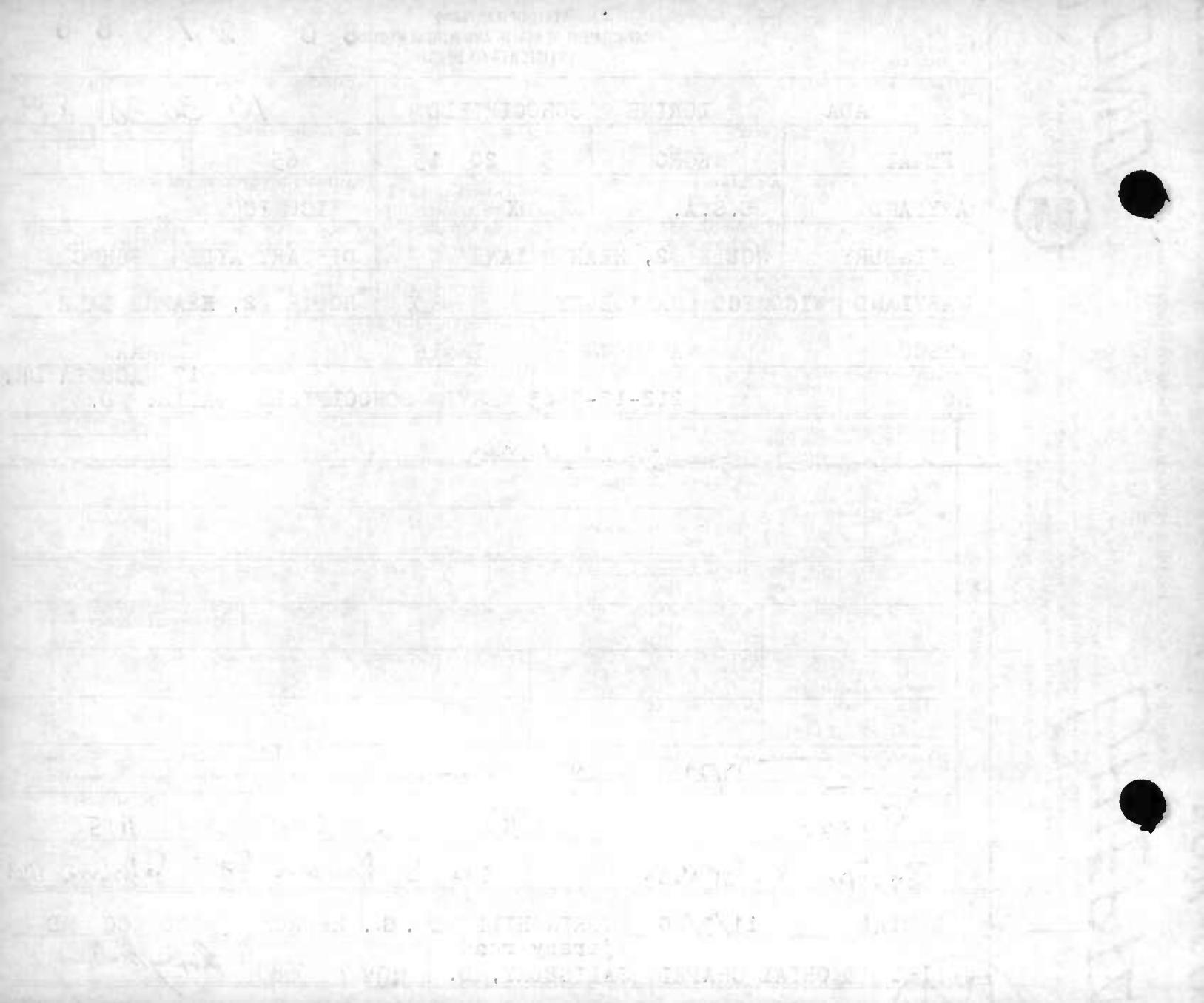
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3 0 2 7 0 8 7	
1 - STATE REGISTRAR												REG. NO.	
I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
ELIZABETH GROVER Scheurmann						October 9, 1980			11:05				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
FEMALE		WHITE		FEB. 21, 1908			72			IF UNDER 24 HRS MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico			10. CITY OR TOWN OF DEATH Salisbury			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF INSTITUTION, GIVE ADDRESS)												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. COUNTY 13b. CITY OR TOWN 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												13e. STREET ADDRESS 75th Street	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS PARK Dr. Beah J. HARTMAN LEBANON, Pa. 17042				
ISAAC J. WHITE			NETTIE Bounds			103-07-8364							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410- DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Cardiovascular Disease												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Renal Failure													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 8-28-1980 to 10-9-1980, that (I) (we) last saw the deceased alive on 10-9-1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22b. SIGNATURE James L. Clegg MD	
22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>												22d. DATE SIGNED 10-9-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS JAMES L. CLIFFORD #12 MEDICAL CENTER PASHISBURY MD										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 10/11/1980			23c. NAME OF CEMETERY OR CREMATORIAL Silohm Con.			23d. LOCATION CITY/TOWN COUNTY STATE Silohm Wic., Md.				
24. FUNERAL DIRECTOR NAME Hill-Boker-Bounds, Pashisbury Md.			25a. DATE REC'D. BY REGISTRAR OCT 14 1980			25b. REGISTRAR'S SIGNATURE Loyalty Belknap							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	0	2	7	0	8	8					
												REG. NO.											
1 - FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST ADA			MIDDLE LORINE			LAST SCHOOLFIELD			2a. DATE OF DEATH MONTH 10			DAY 30		YEAR 80		2b. HOUR 8:00 M	
3. SEX FEMALE			4. RACE NEGRO			5. DATE OF BIRTH MONTH 5			DAY 20			YEAR 15			6. AGE (IN YEARS LAST BIRTHDAY) 65			IF UNDER 1 YEAR MONTHS YRS.		IF UNDER 24 HRS. DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO														
10. CITY OR TOWN OF DEATH SALISBURY			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ROUTE #2, HEARNE LANE			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DIETARY AIDE			12b. KIND OF BUSINESS OR INDUSTRY PGHMC														
13a. STATE MARYLAND			13b. COUNTY WICOMICO			13c. CITY OR TOWN SALISBURY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS ROUTE #2, HEARNE LANE											
14. FATHER'S NAME FIRST TESCO			MIDDLE MATTHEWS			15. MOTHER'S MAIDEN NAME FIRST MINNIE			MIDDLE			LAST HENNMAN											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 212-12-3963			17. INFORMANT MERVIN SCHOOLFIELD			ADDRESS #17 WACONIA DR. SALIS. MD.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gastric Cancer</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
1519 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																							
DUE TO, OR AS A CONSEQUENCE OF (b)																							
DUE TO, OR AS A CONSEQUENCE OF (c)																							
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE									
22a. I certify that (I) <input type="checkbox"/> attended the deceased from saw the deceased alive on <i>10/21</i> 19 <i>80</i> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did <input type="checkbox"/> did not view the body after death.												19 <i>10/21</i> 19 <i>80</i> that (I) <input type="checkbox"/> last											
22b. SIGNATURE <i>Joseph A. Grasso</i>			22c. DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			DATE SIGNED <i>11/5</i>														
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Joseph A. Grasso</i>			22e. ADDRESS <i>1300 S. Division St. Salisbury, Md.</i>																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 11/3/80			23c. NAME OF CEMETERY OR CREMATORIAL SPRINGHILL MEM. C. HEBRON			23d. LOCATION CITY OR TOWN HEBRON			COUNTY WICOMICO		STATE MD									
24. FUNERAL DIRECTOR NAME JOLLEY MEMORIAL CHAPEL			ADDRESS jersey road			25a. DATE REC'D. BY REGISTRAR NOV 7 1980			25b. REGISTRAR'S SIGNATURE <i>Ricky McBrady</i>														

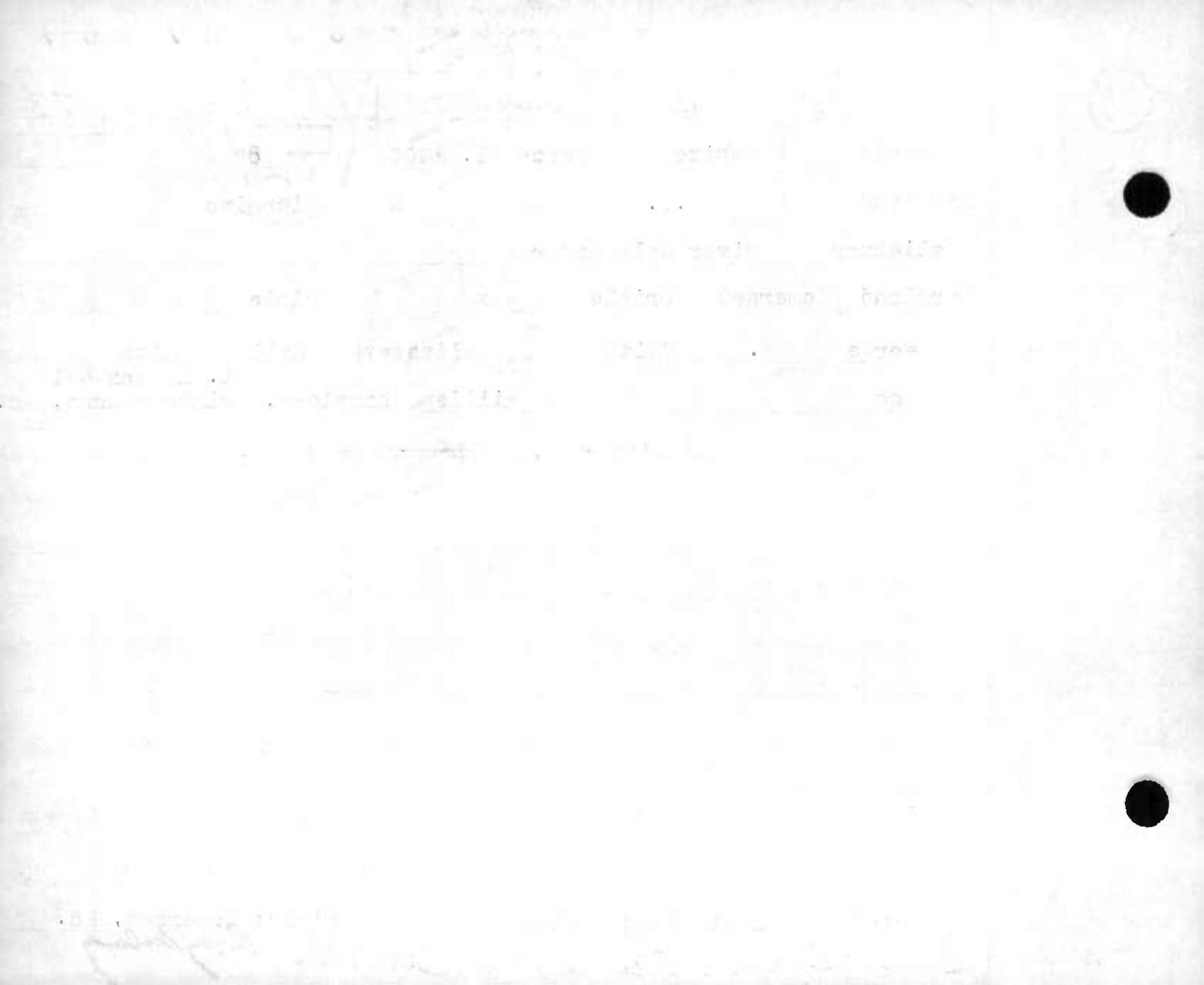


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be detached for use by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 80 27089 CERTIFICATE OF DEATH														
1. FOR STATE REGISTRAR			REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
EISIE			G			SHARPLESS			10-15-80			7:15 PM		
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR March 11, 1900			6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico			MD		
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) River Walk Manor			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland			13b. COUNTY Somerset			13c. CITY OR TOWN Oriole			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Oriole		
14. FATHER'S NAME FIRST MIDDLE LAST George T. Smith			15. MOTHER'S MAIDEN NAME Elizabeth Hall Smith			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS Rt. 1 Box 451 William Sharpless, Princess Anne, Md		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost b) <i>Cerebral Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF c) <i>Gastric ulcer & malnutrition</i> DUE TO, OR AS A CONSEQUENCE OF														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Gastric ulcer & malnutrition</i>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <i>July 18 1980</i> to <i>Oct 15 1980</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>Oct 15 1980</i> and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>Thomas C. Hill Jr.</i>			DEGREE			22c. DATE SIGNED <i>10/20/80</i>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Thomas C. Hill Jr.</i>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS <i>Pine Bluff Road, Salisbury, Md.</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>10/18/1980</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Oriole</i>			23d. LOCATION CITY OR TOWN <i>Oriole, Somerset, Md.</i>					
24. FUNERAL DIRECTOR NAME <i>James L. Dennis</i>			ADDRESS <i>Princess Anne House</i>			25e. DATE REC'D. BY REGISTRAR <i>OCT 27 1980</i>								
BP														
DHMH - 16 50M 1/76 (VR A 15 (4))														





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

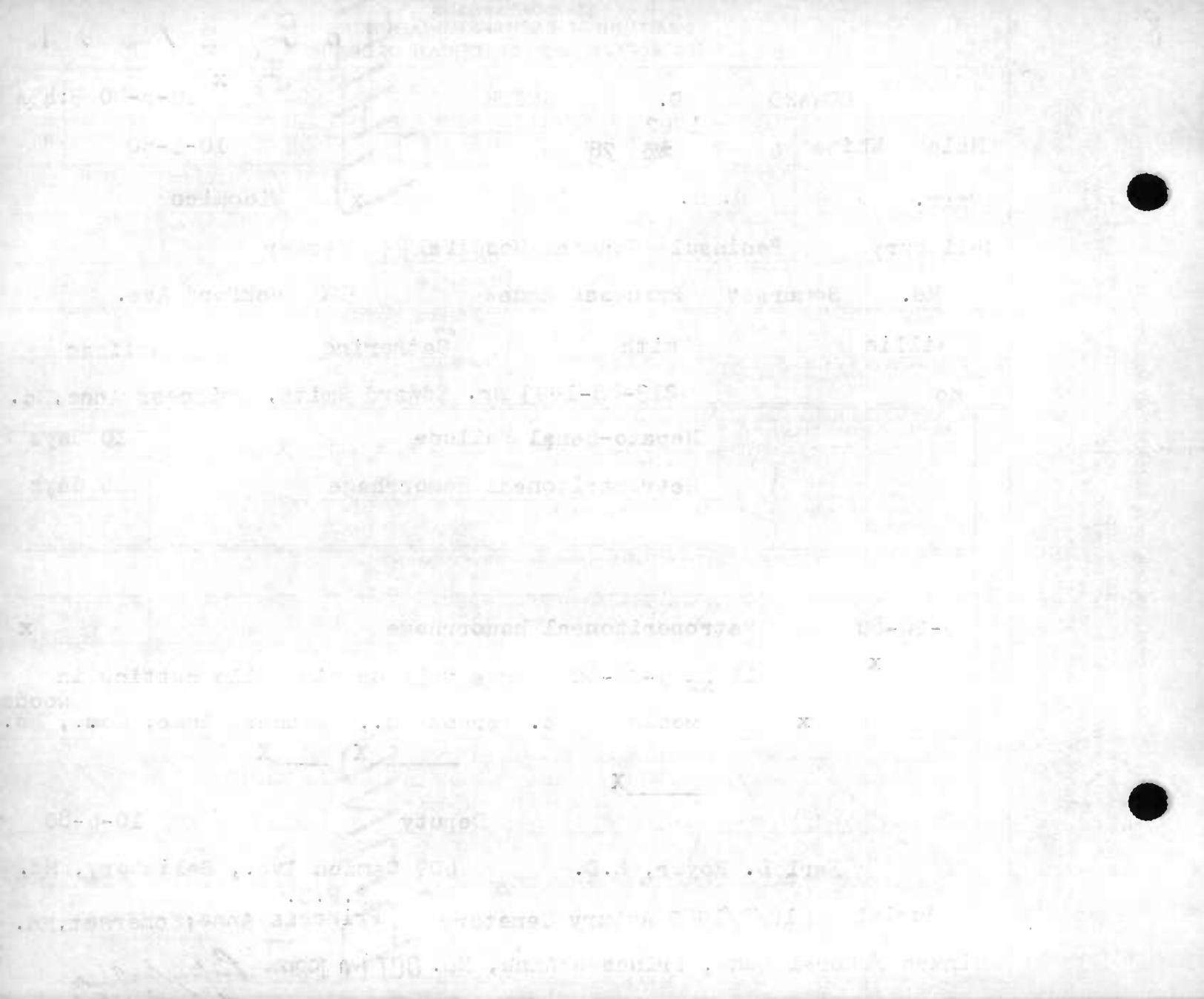
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 27090				
										REG. NO.				
1. FOR STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
	ESTHER			H.		SMACK	October 14, 1980						1:05pm	
3. SEX	4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female	White			9-24-19			61			MONTHS	YEARS	MONTHS	YEARS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Maryland	USA						WICOMICO,							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
SALISBURY	Deer's Head Center						haber			Poultry				
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS								
Maryland	Worcester	Snow Hill				211 Belt St.								
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Avery		Hayman	Abbie						Hales					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No	216096583			Alton L. Smack, Snow Hill Md.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										C.H.F.				
4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) Atherosclerotic cardiovascular disease				
DUE TO, OR AS A CONSEQUENCE OF (b)														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 21, 1980, to Oct. 14, 1980, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct. 14, 1980, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death.														
22b. SIGNATURE M. Shrestha					DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/14/80				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Maheswari Shrestha, M.D.		22e. ADDRESS P.O. Box 2018, Salisbury, Md. 21801												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 10-17-80			23c. NAME OF CEMETERY OR CREMATORIUM McKenzie Presby.			23d. LOCATION CITY OR TOWN Snow Hill, Maryland		COUNTY	STATE			
24. FUNERAL DIRECTOR NAME Norman F. Dennis, Snow Hill, Md.		ADDRESS			25a. DATE REC'D. BY REGISTRAR OCT 21 1980			25b. REGISTRAR'S SIGNATURE Linda A. Clark						

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

80 27091
REG. NO.

1- FOR STATE REGISTRAR		I. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- MATED		2b. MONTH DAY YEAR	2b. HOUR 19 M								
		EDWARD D. SMITH										<input checked="" type="checkbox"/>		10-6-80	5:45A								
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS (LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR	2d. HOUR 19 M								
Male		White		1902 6 7 1983		78 yrs.		MONTHS		DAYS HOURS MIN		<input checked="" type="checkbox"/>		10-6-80	11								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED WIDOWED		NEVER MARRIED DIVORCED				9. BALTIMORE CITY OR COUNTY OF DEATH											
Nebr.		U. S.				<input type="checkbox"/>		<input type="checkbox"/>				Wicomico											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY													
Salisbury		Peninsula General Hospital				Farmer																	
13. STATE		13a. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS															
Md.		Somerset		Princess Anne		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		520 Beckford Ave.															
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME															
		Willie				Smith		Catherine															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.				17. INFORMANT		ADDRESS															
no		213-48-1993				Mr. Edward Smith, Princess Anne, Md.																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepato-Renal Failure DUE TO, OR AS A CONSEQUENCE OF 916- Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) Retroperitoneal Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).														16 days									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?																	
9-20-80		Retroperitoneal hemorrhage				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
		11 AM 9-20-80		Tree fell on him while cutting in woods																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE																			
		woods		Mt. Vernon Rd., Princess Anne, Som., Md.																			
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/>		and in my opinion																			
ACTUAL SIGNATURE <i>Earl L. Royer</i>		M.D.		TITLE (SPECIFY) Deputy		MEDICAL EXAMINER																	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		DATE SIGNED		10-6-80																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION		23e. COUNTY		23f. STATE													
Burial		10/8/1980		Asbury Cemetery		R.F.D.		Princess Anne		Somerset													
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE																	
Hinman Funeral Home, Princess Anne, Md.				OCT 10 1980		<i>Hinman Funeral Home</i>																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, copy 1 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 7 0 9 2
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			LOUISE	MAE	TERRY	OCTOBER	4	1980		7 A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		BLACK		MONTH APRIL DAY 15 YEAR 28		52		YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Maryland PRINCESS ANNE		USA				Wicomico					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury		Peninsula General Hospital				r domestic		housewife			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD		13b. COUNTY WICOMICO		13c. CITY OR TOWN PARSONSBURG		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Rt. #1, Forest Grove Rd			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
CHARLESTON				HUTCHINSON		CARRIE ELIZABETH				CANNON	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
NO		215-20-1930		FRANK TERRY SR.		Same as above		1 day			
431-						Cerebral hemorrhage					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF Hypertension							
		(c)		DUE TO, OR AS A CONSEQUENCE OF							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10-4-80, to 10-4-80, that (I) (we) last saw the deceased alive on 10-4-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22c. DATE SIGNED	
WILBER R. ELLIS MD										10-4-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		11. ADDRESS									
WILBER R. ELLIS MD		KAY AVE SALISBURY MD 21801									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
BURIAL		10/8/80		Springhill Memory		Hebron		Wicomico		Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Jolley Memorial Chapel		Rt. #2, Jersey Rd. Salis. Md.		OCT 8 1980		Lenny Melody					

testimony. Testimony, evidence, evidence

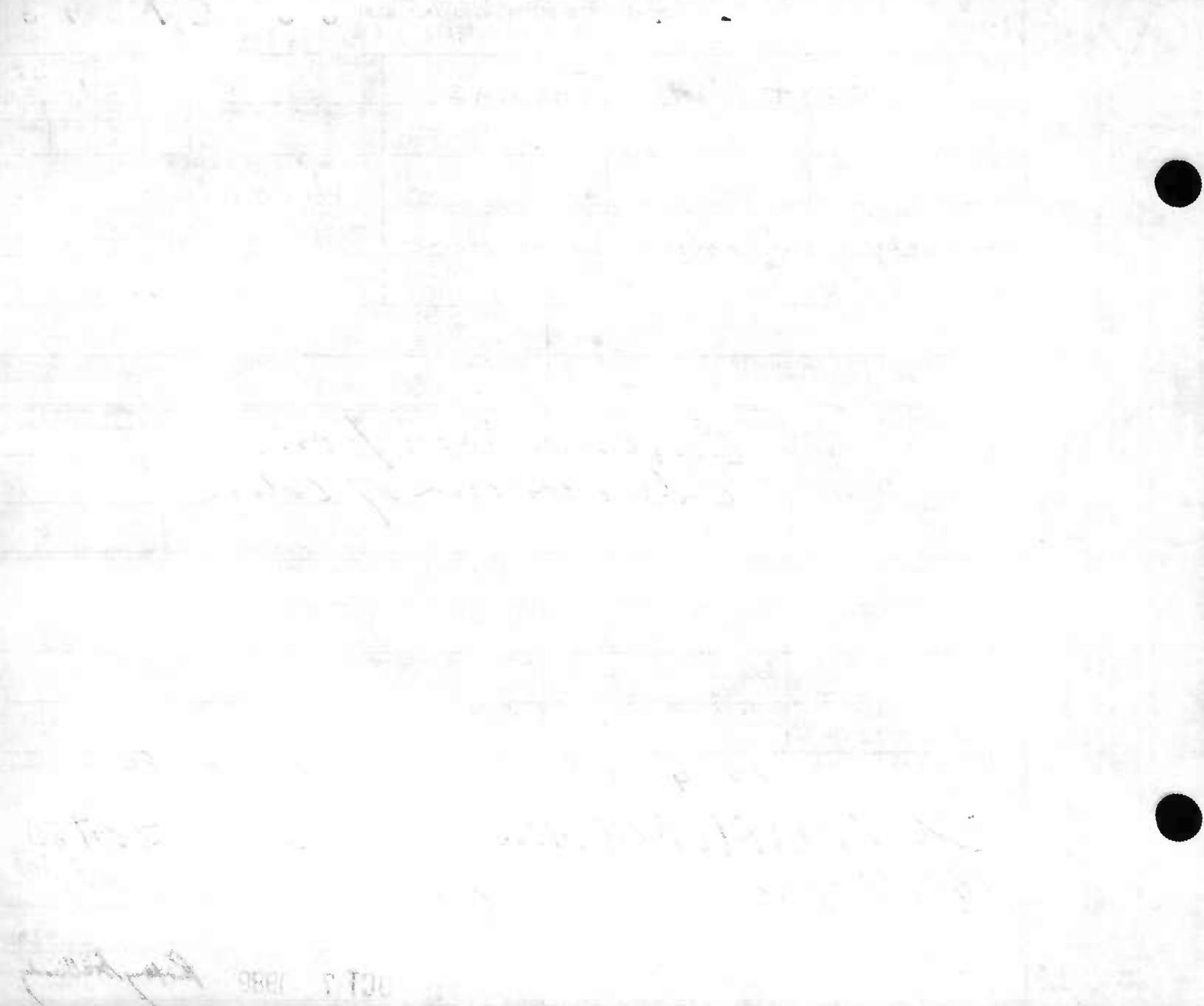
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-travel permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8027093
1 - STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR								REG. NO.
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST			2b. HOUR		2b. HOUR			
BURT Holman Thomas					10 - 2 - 80		12 48			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 14, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.				
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wicomico Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Employee		12b. KIND OF BUSINESS OR INDUSTRY Battery Company				
13a. STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Hebron		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 323 Lillian St., Box 545		
14. FATHER'S NAME FIRST MIDDLE LAST Frank		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Thomas Bertha		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-10-8897		17. INFORMANT ADDRESS Mrs: Brookside Thomas (wife) same as 13		
18. CAUSE OF DEATH (Enter only one cause per line, or (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		18. DUE TO, OR AS A CONSEQUENCE OF (b) <i>Circumstances from</i> <i>adverseness of colon</i>		18. DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 07-30 1980 to 10-02 1980, that (I) (we) last saw the deceased alive on 09-09 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Donald W. Mitchell</i>		22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 30/10/80						
22e. PHYSICIAN'S NAME (TYPE OR PRINT) D.C. Mitchell		22f. ADDRESS POB 2378 Salisbury, Md. 21801								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/6/80		23c. NAME OF CEMETERY OR CREMATORIAL Hebron Cemetery		23d. LOCATION CITY OR TOWN Hebron, Wicomico		COUNTY STATE Maryland		
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Maryland		25a. DATE REC'D. BY REGISTRAR OCT 7 1980		25b. REGISTRAR'S SIGNATURE <i>Henry McBrady</i>						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

Y/R/4-~

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				80 27094
				REG. NO.
1. DECEASED NAME (TYPE OR PRINT)				2b. DATE OF DEATH MONTH DAY YEAR
George Delmas Thomas				10 9 80
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Jan. 26, 1907	6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	2b. HOUR 2:20 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO	
10 CITY OR TOWN OF DEATH SALISBURY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PENINSULA GENERAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist
13a. STATE Maryland	13b. COUNTY Wicomico	13c. CITY OR TOWN Salisbury	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 15 Coulbourne Drive
14 FATHER'S NAME FIRST Wesley	MIDDLE George	LAST Thomas	15 MOTHER'S MAIDEN NAME FIRST Bessie	MIDDLE LAST Catherine Hopkins
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO 220-12-1549	17 INFORMANT Mrs. Elizabeth B. Thomas (wife)	ADDRESS same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for item 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension</u>				50 yrs
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u>				50 yrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>10-7-80</u> to <u>10-9-80</u> , that (I) (we) lost saw the deceased alive on <u>10-9-80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <u>Roger Merrill</u>		DEGREE <u>MD</u>	ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>10-9-80</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <u>KAY AVE SALISBURY MD 21801</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/13/80	23c. NAME OF CEMETERY OR CREMATORIAL Wicomico Mem. Park	23d. LOCATION CITY OR TOWN Salisbury, Wic., Maryland	23e. COUNTY STATE
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md.	ADDRESS		25a. DATE REC'D. BY REGISTRAR OCT 14 1980	25b. REGISTRAR'S SIGNATURE <u>Peter J. Brady</u>

BP



DOE INDEX

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 27095
1. FOR STATE REGISTRAR											REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			20. DATE OF DEATH MONTH DAY YEAR			26 HOUR
Edith L Timmons									October 17 1980 8:40 P.M.			
3. SEX FEMALE			4. RACE NEGRO			5. DATE OF BIRTH MONTH 4 DAY 12 YEAR 96			6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Snow Hill, Md			7b CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER			12b. KIND OF BUSINESS OR INDUSTRY DOMESTIC			
13a. STATE Md			13b. COUNTY Worcester			13c. CITY OR TOWN Berlin			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Box 697 Ironshire Rd
14. FATHER'S NAME FIRST MIDDLE LAST Sammy Duncan			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Catherine Wright									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 219-04-4058			17. INFORMANT Sylvester Date			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 Severe aortoemia			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			(b)			DUE TO, OR AS A CONSEQUENCE OF Congestive heart failure						
			(c)			DUE TO, OR AS A CONSEQUENCE OF Atherosclerotic heart disease						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. Diabetes Sickle cell anaemia - Permanent pacemaker for AV block												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) 9/25/80						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 10/17/80 19 to 10/17/80 19, that (I) (we) last saw the deceased alive on 10/17/80 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE B. Agarwal			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 10/17/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BAL AGARWAL			22e. ADDRESS PCN Salisbury									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 10-22-80			23c. NAME OF CEMETERY OR CREMATORIAL CALVARY A.M. Cemetery			23d. LOCATION CITY OR TOWN Suponque Worcester Md			COUNTY STATE
24. FUNERAL DIRECTOR NAME Jolley Memorial Chapel			ADDRESS R+2 Jersey Road Salisbury			25a. DATE REC'D. BY REGISTRAR OCT 24 1980			25b. REGISTRAR'S SIGNATURE L. Jolley			

Photograph

Over. # 8100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

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MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

80 27096

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Robert Nelson Topping						October 9, 1980				4 AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE IN YEARS LAST BIRTHDAY		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS MONTHS HOURS MIN.	
Male		Caucasian		Oct 14 1913		60					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Va.		U.S.A.				Wicomico					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (TYPE OR PRINT)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Salisbury		Peninsula General Hospital		Waterman		Sea Food					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
13a. STATE Md. 13b. COUNTY Worcester 13c. CITY OR TOWN Ocean City						13e. STREET ADDRESS Fleetway Drive, Rt 1 Box 290-1					
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Crosby		-	Topping	Hattie T. Topping							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
No		216-14-9970		Mrs. Julia A. Holden Rt 1, Box 290-1, Ocean City, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Cardiogenic shock</u>											
410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe transmural myocardial infarction</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Previous inferior myocardial infarction</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from <u>10/8/80</u> , 19 <u>80</u> , to <u>10/9/80</u> , 19 <u>80</u> , that (2) (we) lost the deceased alive on <u>10/8/80</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.											
22b. SIGNATURE <u>Clayton Lee Roat</u>		DEGREE									
22c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 10-9-80									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Clayton Lee Roat m.s. Lound & Quincy sr's Salis. Drs. 2801</u>		22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/11/80		23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park		23d. LOCATION CITY OR TOWN Berlin		23e. COUNTY Wor. Md.			
24. FUNERAL DIRECTOR NAME Anna A. Bubba		ADDRESS 108 William St, Berlin Md		25a. DATE REC'D. BY REGISTRAR OCT 14 1980		25b. REGISTRAR'S SIGNATURE <u>Patricia McElroy</u>					

12

1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

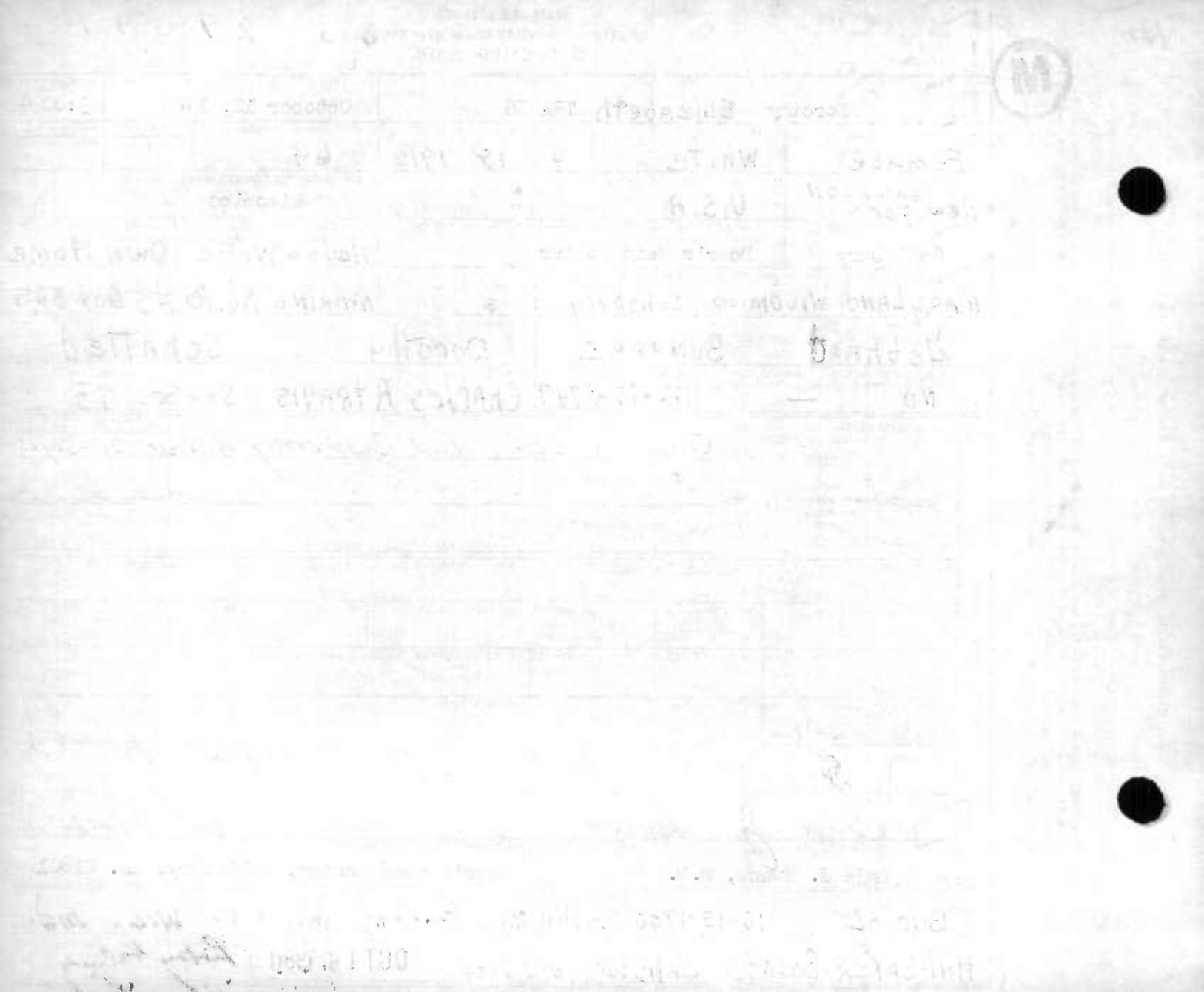
0 27097

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Dorothy Elizabeth TRAVIS						October 12, 1980				3:00 A M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		4 18 1916		64		YRS		MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Brooklyn New York		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico		MD.	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Wife		12b. KIND OF BUSINESS OR INDUSTRY Own Home					
13a. STATE MARYLAND		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS MARINE Rd. R#5 Box 525			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Hebhard		BUNGARZ		Dorothy Schattet							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. —		16c. ADDRESS CHARLES A TRAVIS See Sec 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 496- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20-30 yrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (the hospital) attended the deceased from 10/12/80 to 10/12/80, shot (I) (we) lost saw the deceased alive on 10/12/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Inja J. Hwang, M.D.		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22d. DATE SIGNED 10/12/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Inja J. Hwang, M.D.		22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-15-1980		23c. NAME OF CEMETERY OR CREMATORIAL Sp. Hill. Mem. Gardens		23d. LOCATION OWN		25a. DATE REC'D. BY REGISTRAR OCT 16 1980		25b. REGISTRAR'S SIGNATURE Linton McCloud	
24. FUNERAL DIRECTOR NAME Hill-Baker-Bounds		ADDRESS Salisbury, Md 21801									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

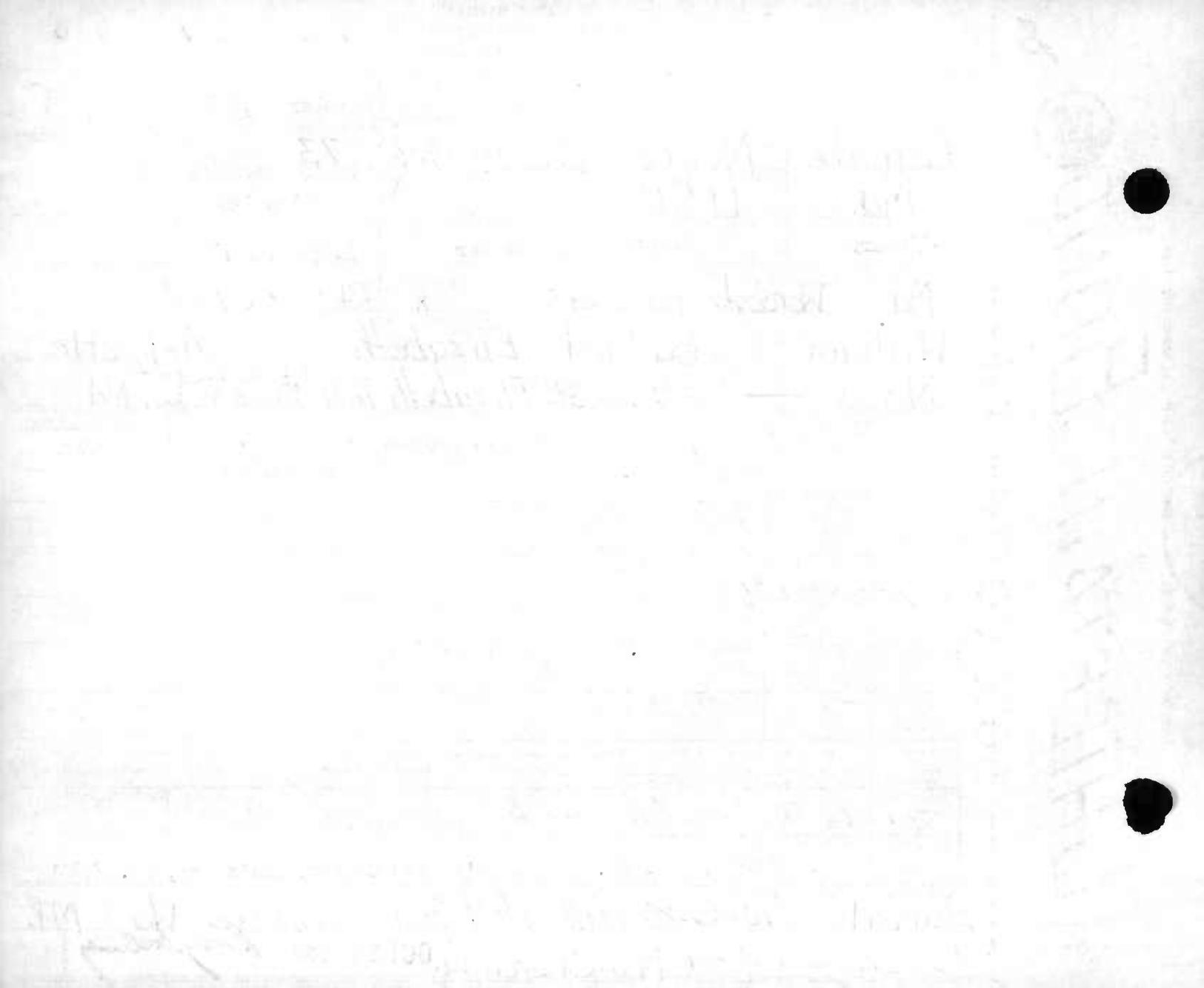




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be completed and completely filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, an other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 0 27098											
										REG. NO.											
1 - FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST CARRIE		MIDDLE TULL		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR 9:30 P.M.								
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH MONTH Dec. 24, 1906 YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. BIRTHPLACE STATE OR FOREIGN COUNTRY Md.		8. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico		10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md.		13b. COUNTY Worcester		13c. CITY OR TOWN Pocomoke		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 2 Bx. 144													
14. FATHER'S NAME FIRST William		MIDDLE Ballard		LAST Elizabeth		15. MOTHER'S MAIDEN NAME FIRST Aydelotte		MIDDLE													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-60-0395		17. INFORMANT Elizabeth Tull		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6mo		ADDRESS Rt. 2 Bx. 144 Pocomoke, Md.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Abdominal neoplasm, etiology unknown</i>																					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>psychosis</i>																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE											
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE <i>Nancy W. Tustin, M.D.</i>										DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NANCY W. TUSTIN, M.D.										22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-22-80		23c. NAME OF CEMETERY OR CREMATORIAL Halls Hill Cem.		23d. LOCATION CITY OR TOWN Pocomoke		23e. COUNTY Wicomico		23f. STATE Md.											
24. FUNERAL DIRECTOR NAME <i>Nancy Tustin</i>										25a. DATE REC'D. BY REGISTRAR OR BURIAL DIRECTOR OCT 27 1980 <i>Parry, H. T. Tustin</i>											
ADDRESS Deer's Head Center, Salisbury, Md. 21801																					

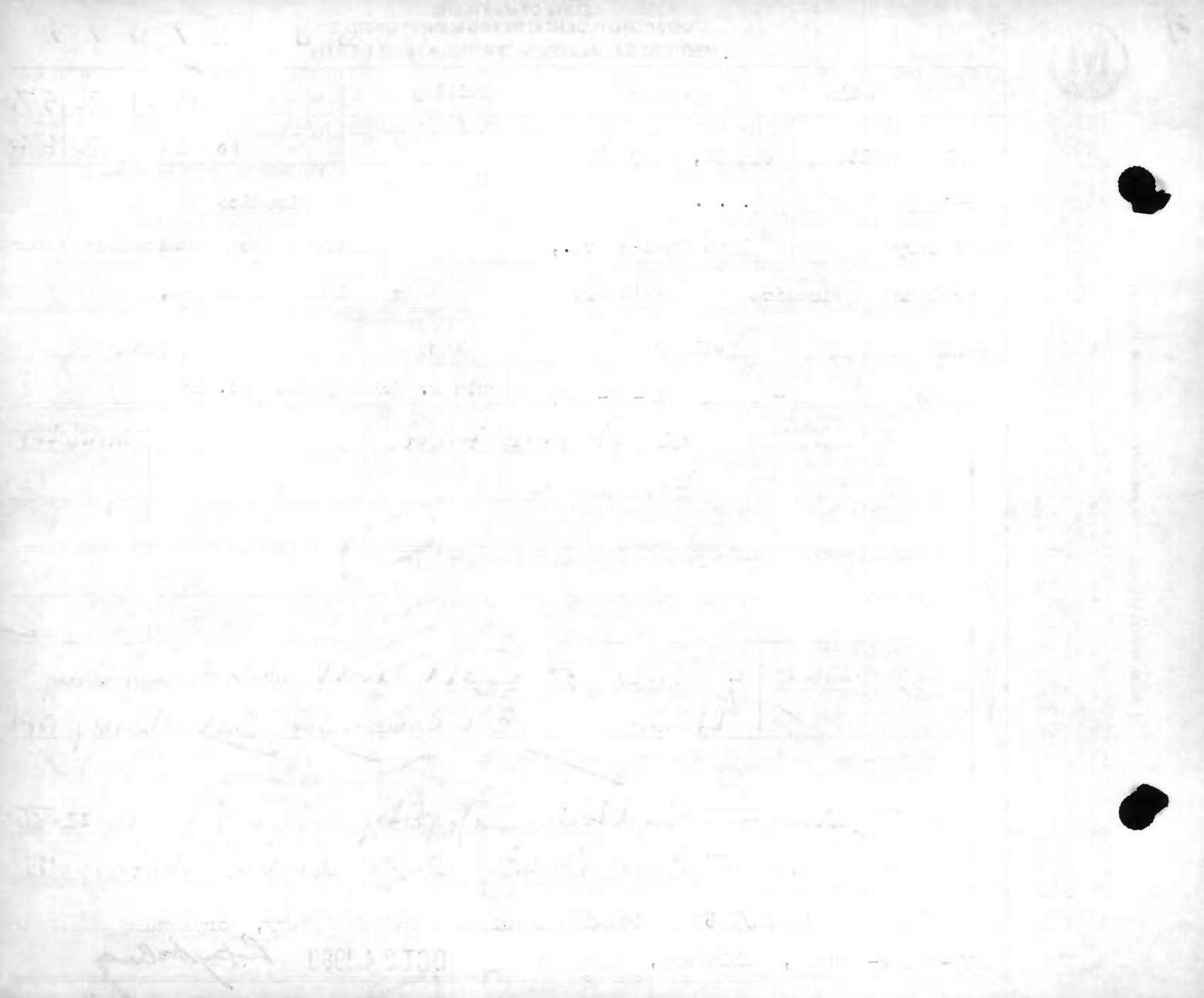


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES.
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIORITY BURIAL CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

27099
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Otis	MIDDLE Spooner	LAST Twilley	2a. DATE KNOWN OF DEATH ESTIMATED	MONTH 10	DAY 21	YEAR 1980	2b. HOUR 5:29 PM		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD	MONTH 10	DAY 21	YEAR 1980	2d. HOUR 6:57 PM 24 HOUR		
Male	White	Jan 12, 1899	81 yrs.									
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Maryland		U.S.A.					Wicomico					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Salisbury		1206 Camden Ave.,			Retired Seed		Wholesaler Owner					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS							
Maryland	Wicomico	Salisbury			1206 Camden Ave.,							
14. FATHER'S NAME FIRST John		MIDDLE Twilley	15. MOTHER'S MAIDEN NAME FIRST Anna		MIDDLE Baumgartner	LAST						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS						
No		220-32-8067		Ruth R. Twilley See Sec. 13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: 9/33 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes	
<p>IMMEDIATE CAUSE (a) <u>asphyxiation</u> DUE TO, OR AS A CONSEQUENCE OF</p> <p>(b) <u>trauma</u> DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c)</p>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4 P.M. 10-21 1980		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		wall fell, while dismantling						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		1206 Camden Ave Salisbury MD						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>John T. Bulkeley</i>		TITLE (SPECIFY) M.D.			MEDICAL EXAMINER						DATE SIGNED 10-22-80	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 504 E. 1st St. to Sec. Salisbury Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 10/24/1980		23c. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Park		23d. LOCATION CITY OR TOWN Salisbury, Maryland		CITY OR TOWN COUNTY STATE				
24. FUNERAL DIRECTOR NAME Hill-Baker-Bounds, Salisbury, Maryland		25a. DATE REC'D. BY REGISTRAR OCT 24 1980		25b. REGISTRAR'S SIGNATURE <i>Hilary McCrea</i>								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with a 72 hour after death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8027100	REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
GERALD William VICKERS						October 18 1980			3:32 PM				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
Male		White		Aug. 22, 1936			44 YRS.			MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Florida		USA					Wicomico						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Salisbury		Peninsula General Hospital					Retired employee Pump Mfg.						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13b. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			
Maryland		Wicomico		Salisbury						Mobil Home Park Cedarhurst Village			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
William E. Vickers		Helen Jackson											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Yes		218-30-1723A		Mrs. Shirley A. Vickers (wife)						same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident</i>													
436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF													
6 days													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Acute Inferior Wall Myocardial Infarction</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
19b. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____								
22a. I certify that (I) (this hospital) attended the deceased from <u>OCT 12</u> , 19 <u>80</u> , to <u>OCT 18</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>Oct 18 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>S. A. Abrams</i>		DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>10/24/80</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>S. A. Abrams MD</i>		22e. ADDRESS <i>PENINSULA GENERAL HOSPITAL, SALISBURY, MD</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIAL)		23b. DATE <i>10/21/80</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Parsonsburg Cemetery, Parsonsburg, Wic., Md.</i>			23d. LOCATION CITY OR TOWN _____ COUNTY _____ STATE _____						
Burial													
24. FUNERAL DIRECTOR <i>HOLLOWAY FUNERAL HOME, Salisbury, Md.</i>		ADDRESS <i>NAME</i>			25a. DATE REC'D. BY REGISTRAR <i>OCT 21 1980</i>			25b. REGISTRAR'S SIGNATURE <i>photograph</i>					

M

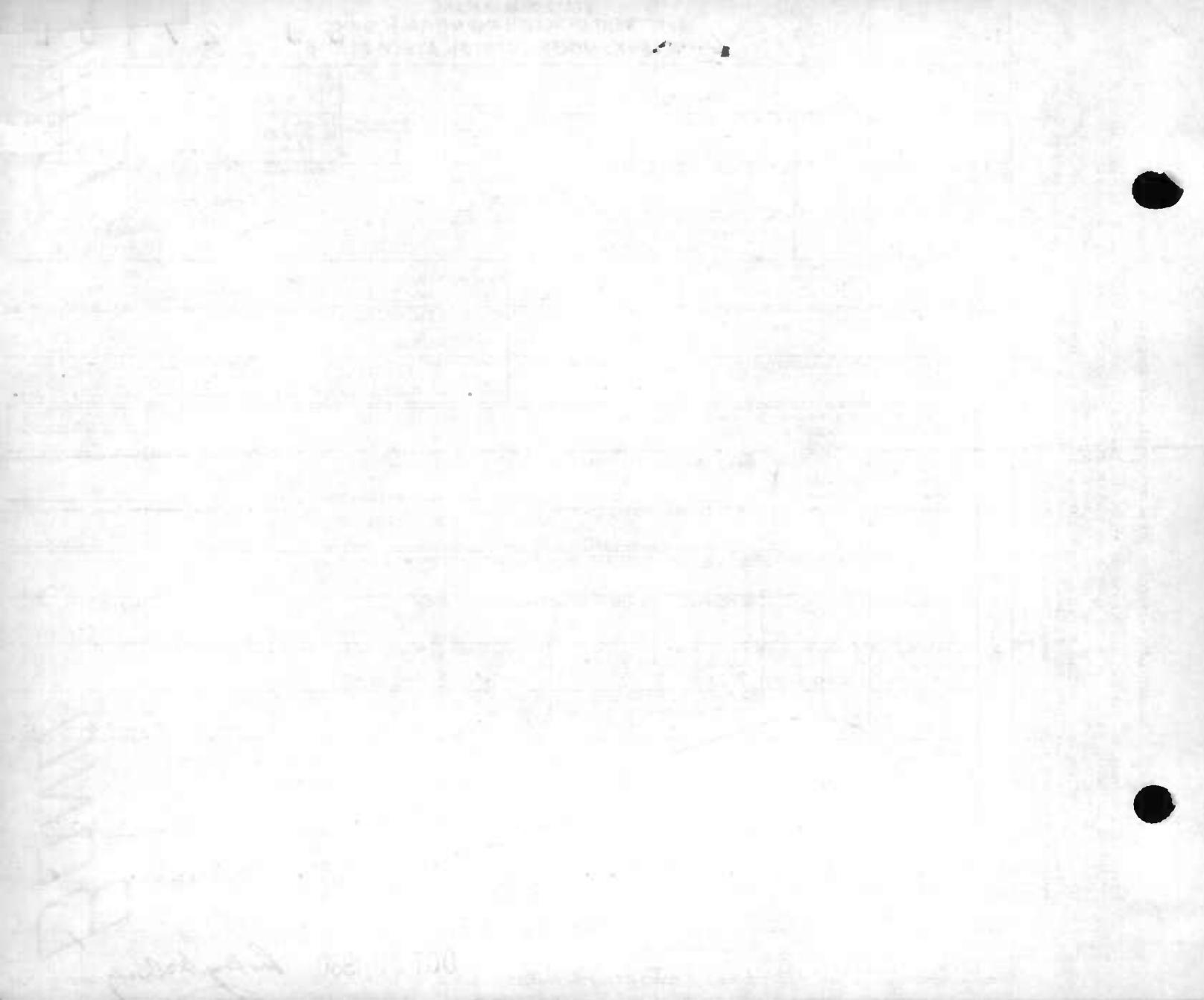
1

Debt w/ 3rd party creditors - 200,000

Guaranteed 08/13/20

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 80 27101					
1- FOR STATE REGISTRAR			2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 10 17 1980									2b. HOUR MONTH DAY YEAR 2d. HOUR 10 20 1980 4:00P					
I. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST								
John Michael Wagner																	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.							
Male		White		3/23/1948		32 yrs.											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8.		9. BALTIMORE CITY OR COUNTY OF DEATH											
Maryland		USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Wicomico County, MD.											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Salisbury			Wicomico River - Bank						Laborer			Waterman					
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS								
Virginia			Princess Ann		Virginia Beach		YES <input type="checkbox"/> NO <input type="checkbox"/>		Suite 420 Pembrook #1								
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST			
Michael						Wagner			Margaret			Pauline		Wallick			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)						17. INFORMANT			ADDRESS					
Unknown			216-48-9394						(father) Mr. Michael Wagner, Satellite Beach, Fla.			730 Verbenia Dr.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 10 17 1980			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject drowned											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) water			21f. LOCATION STREET Wicomico River			CITY OR TOWN Salisbury		COUNTY Wicomico	STATE MD.					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion														
ACTUAL SIGNATURE			TITLE (SPECIFY) Thomas D. Smith, M.D.			M.D. Deputy Chief MEDICAL EXAMINER			DATE SIGNED 10/21/80								
EXAMINER'S NAME (TYPE OR PRINT)									ADDRESS 111 Penn St. Balto., MD.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 10/28/80			23c. NAME OF CEMETERY OR CREMATORIAL Delmarva Crematory			23d. LOCATION CITY OR TOWN Lewes, Sussex, Delaware			COUNTY STATE					
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Maryland			ADDRESS			25a. DATE REC'D. BY REGISTRAR OCT 30 1980			25b. REGISTRAR'S SIGNATURE Holloway								
BP																	
DHMH-17 (VR A15 ME(5)) 15M 7/76																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial and Mental Hygiene permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 27102	REG. NO.
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
LOUISE M. WHALEY									10/11/80			6:15 P.M.	
2c SEX FEMALE			4 RACE CAUCASIAN			5 DATE OF BIRTH MONTH DAY YEAR 6 19 96			6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD				
10 CITY OR TOWN OF DEATH SALISBURY			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PENINSULA GENERAL HOSPITAL			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY HOME				
13a STATE MARYLAND			13b COUNTY WORCESTER			13c CITY OR TOWN OCEAN CITY			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 1582 TEAL DR., MALLARD ISL.	
14 FATHER'S NAME THOROGOOD			15. MOTHER'S MAIDEN NAME MASON SUSAN DICKERSON			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b SOCIAL SECURITY NO 213-42-0354			17 INFORMANT ADDRESS THERESA B. GIBBS, OCEAN CITY, MD.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 1629			DUE TO, OR AS A CONSEQUENCE OF (b) LUNG CARCINOMA									APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH over 6 mos.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) LUNG CARCINOMA									2 1/2 years	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DIVERTICULITIS													
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (s)he (this hospital) attended the deceased from Sept. 22 1980 to Oct. 11 1980, that (s)he (we) last saw the deceased alive on Oct. 11 1980, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (s)he (we) (did) (did not) view the body after death.													
22b. SIGNATURE Allen W. Justin, M.D.			22c. DEGREE			22d. DATE SIGNED Oct. 11, 1980							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Allen W. Justin			22f. ADDRESS 209 Maryland Ave., SALISBURY, MARYLAND										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 10/12/80			23c. NAME OF CEMETERY OR CREMATORIAL WHALEY CEMETERY, WHALEYVILLE, W. Va.			23d. LOCATION CITY OR TOWN COUNTY STATE W. Va. MD				
24. FUNERAL DIRECTOR NAME WATSON & WHALEY, SELBYVILLE, DE			ADDRESS			25a. DATE REC'D. BY REGISTRAR OCT 16 1980			25b. REGISTRAR'S SIGNATURE Lester Whaley				

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The physician retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached from the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

with the State of New York, at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

0 27103

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
REGINALD HENRY WHEATLEY								10/25 180						9:30 P.M.	
3. SEX		4 RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS				
MALE		WHITE	MONTH 12 DAY 09 YEAR 22			57 yrs			MONTHS	DAYS	HOURS	MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
USA		USA						Wicomico							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
SALISBURY		HOLLY CENTER			NONE										
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS						
Md.		DORCHESTER		CAMBRIDGE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			406 Robbins St.						
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST					
		LEE	ONDOS	WHEATLEY	LYDIA			R		WHEATLEY.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
No		217-74-6977			Mrs. Lydia Wheatley, Cambridge, Md.			minutes							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															
PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Cardiac Arrest.															
DUE TO, OR AS A CONSEQUENCE OF (b) Acute Infarct.															
DUE TO, OR AS A CONSEQUENCE OF (c) Acute Pneumonia															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
Pt had Hematemesis + Hematuria since Aug 80 Tx at Dorchester Hosp. ICU															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
					YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from 10/21/80, 19, to 10/24, 1980, that (I) (we) last saw the deceased alive on 10/25, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we did) (I) (we did) of view the body after death.															
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED							
Orlando Bales M.D.								10/25/80							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS													
ORLANDO BALEA M.D.		623 Ridge Rd. Salisbury, Md. 21801													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION			STATE					
Burial		Oct. 28, 1980		Dorchester Mem. Park, Cambridge, Md.			City of Cambridge								
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE										
Thomas Funeral Home, Cambridge, Md.		NOV 5 1980			Randy Bales										

080 5180
NVA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8027104			
											REG. NO.				
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 8 ²⁰ P.M.			
3. SEX Male			4. RACE Negro			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 84			7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Winton N.C.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico			10. CITY OR TOWN OF DEATH Salisbury			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b. KIND OF BUSINESS OR INDUSTRY Lumber	
13a. STATE MARYLAND			13b. COUNTY Wicomico			13c. CITY OR TOWN Salisbury			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 226 Delaware Avenue			
14. FATHER'S NAME FIRST Walter			LAST Whitehead			15. MOTHER'S MAIDEN NAME FIRST Lucinda									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. —			17. INFORMANT Arie Ella Whitehead			ADDRESS Same as above						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio pulmonary Arrest</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
1539 Conditions, if any, which give rise to immediate cause (a), stating the underlying cause lost.															
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diffusely metastatic Carcinoma of the Colon</u>															
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (1) (this hospital) attended the deceased from <u>10/4</u> , 19 <u>80</u> , to <u>10/6</u> , 19 <u>80</u> , that (1) (we) lost sow the deceased on <u>10/4</u> , 19 <u>80</u> , and that in (m) (our) opinion death occurred on the date and hour and from the causes stated above. (We) did not view the body after death.															
22b. SIGNATURE <u>Robert J. Reilly</u>			22c. DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED 10/7/80						
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Robert J. Reilly MD			22f. ADDRESS P&H Medical Center, Salisbury												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10-12-80			23c. NAME OF CEMETERY OR CREMATORIAL Green Acres Mem. Park			23d. LOCATION CITY OR TOWN Salisbury			COUNTY Wicomico		STATE Md	
24 FUNERAL DIRECTOR NAME Jolley Memorial Chapel			ADDRESS Rt. 2 Jersey Rd Salisbury, Md			25a. DATE REC'D. BY REGISTRAR OCT 14 1980			25b. REGISTRAR'S SIGNATURE <u>Pamela</u>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8027105		
										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
Ann D. Williams						October 8, 1980			5:20 PM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. UNDER 1 YEAR MONTHS DAYS HOURS MIN		
FEMALE		WHITE		MAY 17 1926			54 YRS					
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			WT. COMICO			MD		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
SALISBURY		PENINSULA GENERAL HOSPITAL								P.O. Box 392		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
MARYLAND		WORCESTER		BISHOPVILLE					Hudson			
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME								
JAMES		COLLINS		DELÉPHINE								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NO		220-26-3748		ROWEN C. WILLIAMS, BISHOPVILLE, MD.								
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY												
IMMEDIATE CAUSE (a) Respiratory arrest												
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Lung Cancer												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 5 Oct 80 to 8 Oct 80, 19, that (I) (we) last saw the deceased alive on 8 Oct 80, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE EJ Gluek MD		DEGREE					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-8-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EJ Gluek MD		22e. ADDRESS PGH Salisbury MD 2184										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-11-80		23c. NAME OF CEMETERY OR CREMATORIAL Odd Fellows			23d. LOCATION CITY OR TOWN BISHOPVILLE, WORCESTER, MD		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME WATSON + WHALEY, SELBYVILLE, DEL.		ADDRESS					25a. DATE REC'D. BY REGISTRAR OCT 16 1980		25b. SIGNATURE Hector Gluek			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it may be

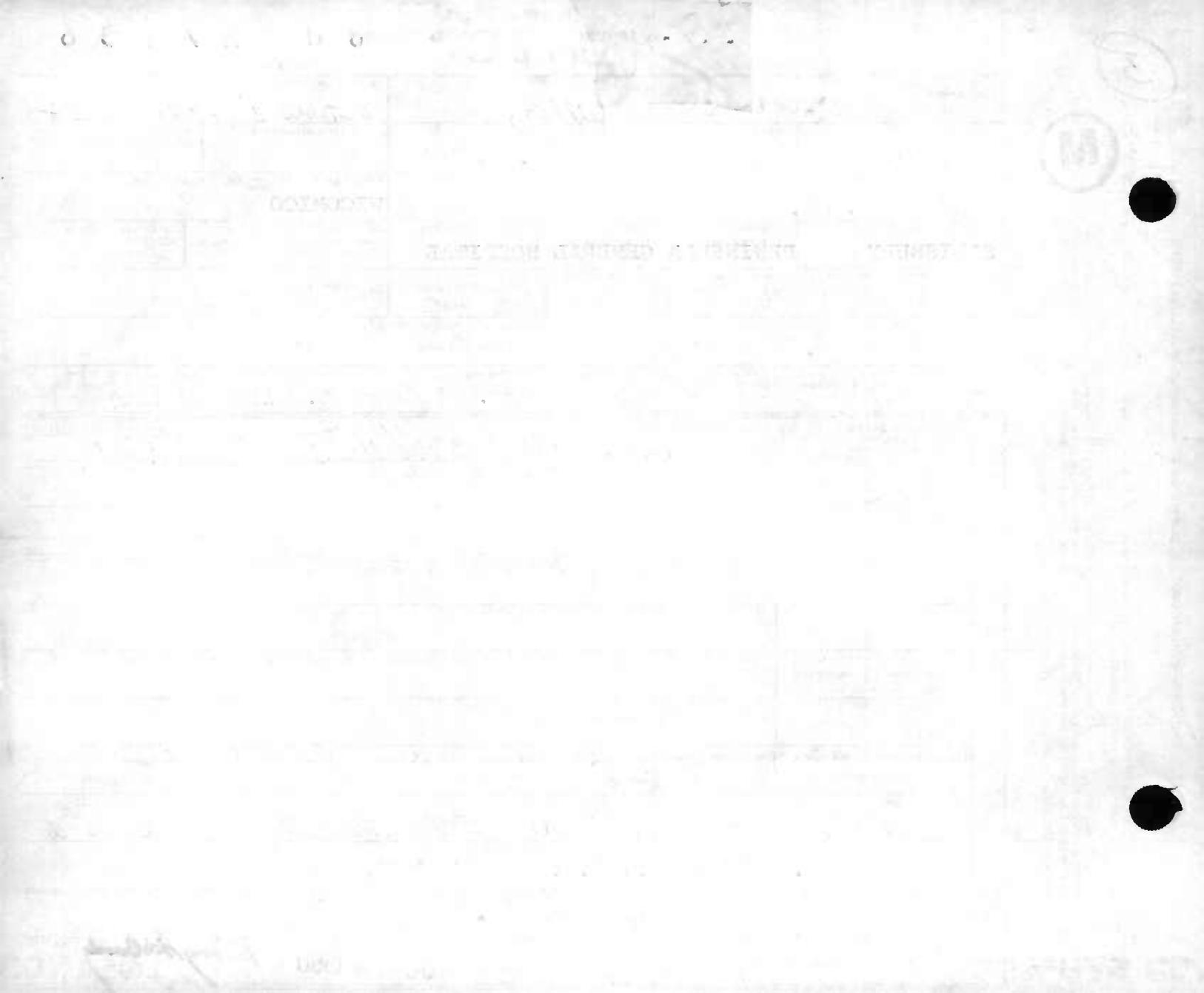
should be detached for use as the burial-tranit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be signed.

FOR 1. STATE REGISTRAR				STATE OF MARYLAND -DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH								3 0 2 7 1 0 6 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR			
Clifford Wailes		Wilson		October 8, 1980		0		27		106		5A M			
3 SEX Male		4 RACE White		5 DATE OF BIRTH Sept. 7, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 68		YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Salisbury, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO		10. CITY OR TOWN OF DEATH SALISBURY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PENINSULA GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Trucker		12b. KIND OF BUSINESS OR INDUSTRY Petro	
13a. STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Naylor Mill Road		14. FATHER'S NAME George H. Wilson		15. MOTHER'S MAIDEN NAME Daisey Belle Pope			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO		16b. SOCIAL SECURITY NO. 214-10-6949		17. INFORMANT Mrs. Florence I. Wilson (wife)		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day		ADDRESS same as 13							
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART 1. DEATH WAS CAUSED BY.</p> <p>IMMEDIATE CAUSE (a) <u>Mycardial infarct</u></p> <p>410 - DUE TO, OR AS A CONSEQUENCE OF</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last</p> <p>(b) _____</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c) _____</p>															
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
<p>22a. I certify that (I) (this hospital) attended the deceased from <u>10-0</u>, 19<u>80</u>, to <u>10-1</u>, 19<u>80</u>, that (I) (we) last saw the deceased alive on <u>10-7</u>, 19<u>80</u>, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p>															
22b. SIGNATURE <u>Wilbur R. Ellis, Jr., M.D.</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-10-80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wilbur R. Ellis, Jr., M.D.		22e. ADDRESS Salisbury, Maryland													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/10/80		23c. NAME OF CEMETERY OR CREMATORIAL Springhill Memory Gardens, Salisbury		23d. LOCATION CITY OR TOWN Wicomico		23e. COUNTY		STATE Maryland					
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Maryland		ADDRESS		25a. DATE REC'D. BY REGISTRAR OCT 14 1980		25b. REG. TRAY Holloway		25c. DATE REC'D. BY TRAY Holloway							

BP _____

DHMH-16 25M
(VRA 15, 4) 1/79



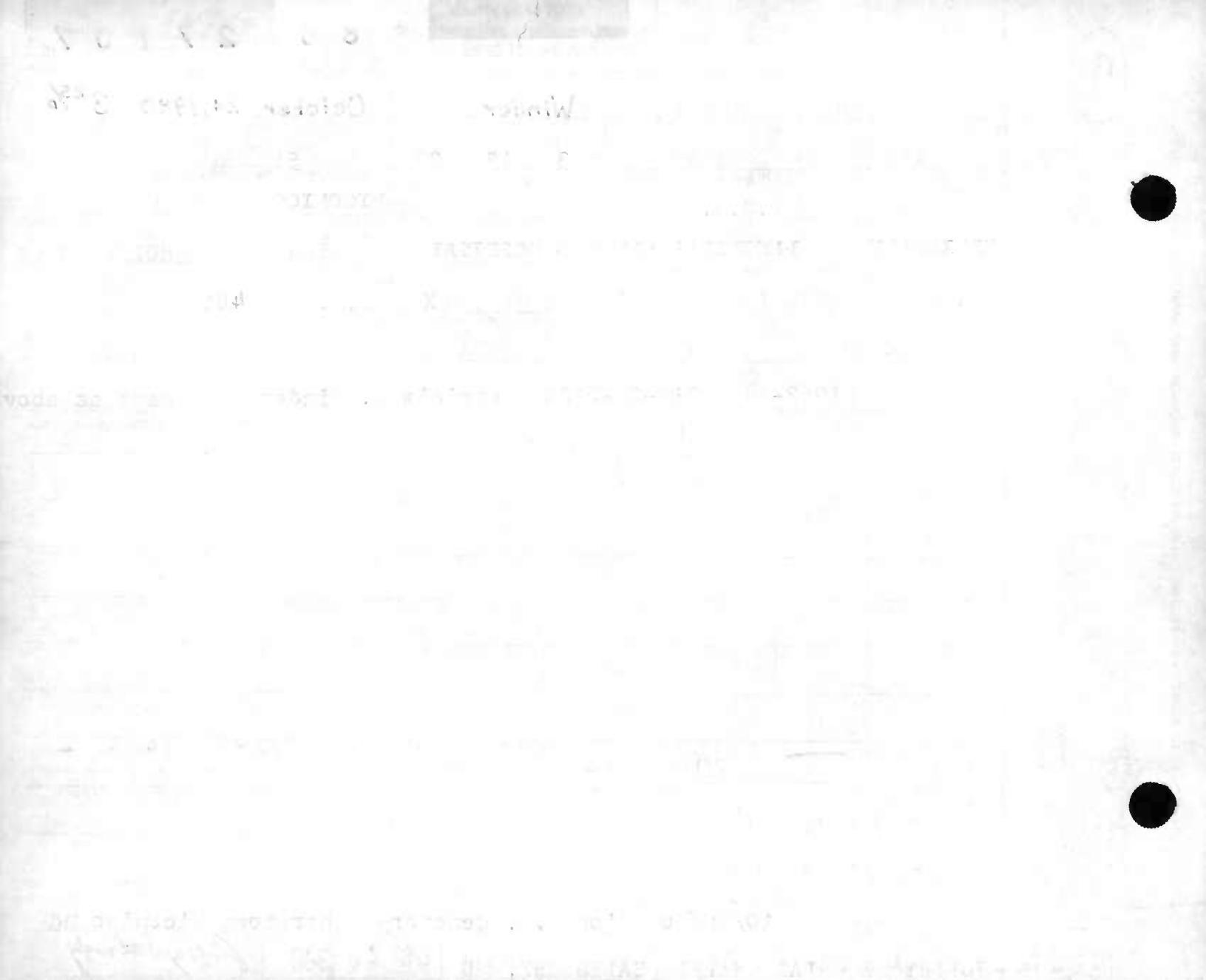
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8027107								
												REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
JOHNNIE RUDOLPH									Winder			October 24, 1980				3 25/PM				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS					
MALE			NEGRO			MONTH 3			DAY 13			YEAR 29			MONTHS 51			DAYS YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
MD			U.S.A.									WICOMICO								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
SALISBURY			PENINSULA GENERAL HOSPITAL			LABORER			HOLLY CNTR											
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13b. STREET ADDRESS								
13a. STATE MARYLAND			13b. COUNTY WICOMICO			13c. CITY OR TOWN HEBRON			13d. INSIDE CITY LIMITS?			P.O. BOX 401								
YES			1952-54			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST					
JAMES						WINDER			EMMA						HEATH					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			16c. INFORMANT			17. ADDRESS			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
YES			1933-24-2320			Patricia A. Winder														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY																				
IMMEDIATE CAUSE (a) <u>Lung Cancer</u>																				
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												DUE TO, OR AS A CONSEQUENCE OF								
{ (b) _____												DUE TO, OR AS A CONSEQUENCE OF								
{ (c) _____																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE								
22a. I certify that (I) (was hospitalized) attended the deceased from <u>10/10</u> , 19 <u>80</u> , to <u>10/24</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>10/24</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE <u>Joseph A. Grasso MD</u>												DEGREE			22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Joseph A. Grasso</u>												ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)												23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		
BURIAL												10/30/80			ZION U.M. CEMETERY			SHARPTOWN WICOMICO MD		
24. FUNERAL DIRECTOR NAME <u>Jolley Memorial Chapel</u>												ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <u>John Kennedy</u>		
															OCT 28 1980					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8027108							
1 - FOR STATE REGISTRAR			20. DATE OF DEATH MONTH DAY YEAR OCTOBER 23, 1980									26. HOUR 55 10 A M							
1. DECEASED NAME (TYPE OR PRINT) HUBERT LEE WORTH			2. FIRST MIDDLE LAST			3. SEX male			4. RACE white			5. DATE OF BIRTH MONTH DAY YEAR Aug. 20, 1885			6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.										
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired farmer			12b. KIND OF BUSINESS OR INDUSTRY										
13a. STATE Maryland			13b. COUNTY Somerset			13c. CITY OR TOWN Rehobeth			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS rural							
14. FATHER'S NAME FIRST John MIDDLE Henry LAST Worth			15. MOTHER'S MAIDEN NAME FIRST Annie MIDDLE Lee LAST Potter																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 261-52-7583			17. INFORMANT ADDRESS Route - Box 250 Jean Taylor Pocomoke City, Maryland													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Standstill</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
5770 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.																			
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Severe over whelming pneumonia</i>																			
DUE TO, OR AS A CONSEQUENCE OF (c) _____																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from 10/21/80 to 10/25/80, that (I) (we) last saw the deceased alive on 10/23/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.												22c. DATE SIGNED 10/23/80							
22b. SIGNATURE <i>Philip A. Insley Jr.</i>			22d. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>													
22e. PHYSICIAN'S NAME (TYPE OR PRINT) PHILLIP A. INSLEY JR. MD			22f. ADDRESS MEDICAL CENTER SAVSBURY MD 21801																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/26/80			23c. NAME OF CEMETERY OR CREMATORIAL Rehobeth Pres. Cem.			23d. LOCATION CITY OR TOWN Rehobeth Somerset Md.										
24. FUNERAL DIRECTOR NAME Sue S. Melson			ADDRESS Pocomoke City, Md.			25. DATE REC'D. BY REGISTRAR OCT 28 1980			25b. REGISTRAR'S SIGNATURE <i>Henry Melson</i>										

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Technique Definition

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